

Assessment in Dance/Movement Therapy Practice: A State of the Field Survey

A Thesis

Submitted to the Faculty

of

Drexel University

by

Megan Andre Powell

in partial fulfillment of the

requirements for the degree

of

Master of Arts in Creative Arts in Therapy: Dance/Movement Therapy

August 2008

© Copyright 2008
Megan A. Powell.
All Rights Reserved

DEDICATIONS

To my friends and family
for their continued support throughout this thesis and graduate school process, their
unwavering love and guidance will always be with me.

ACKNOWLEDGEMENTS

To the members of my thesis committee: Sherry Goodill, PhD., ADTR, NCC, LPC

Suzanne C. Hastie, MA, ADTR, NCC, LPC

Nana Koch, Ed.D, ADTR, NCC, LCAT, LPC

Thank you for your wisdom and support throughout this thesis process.

TABLE OF CONTENTS

ABSTRACT	x
1. INTRODUCTION.....	1
2. LITERATURE REVIEW.....	4
2.1 Overview.....	4
2.2 Role of Assessment in Clinical Practice.....	4
2.2.1 Dance/Movement Therapy Scope.....	4
2.2.2 Mental Health Scope.....	12
2.3 Research to Inform DMT Assessment.....	15
2.4 Examples of DMT Assessment Instruments.....	19
2.4.1 Movement Psychodiagnostic Inventory.....	19
2.4.2 Nonverbal Assessment of Family Systems.....	20
2.4.3 Kestenberg Movement Profile.....	21
2.4.4 Psychiatric Movement Assessment Scale.....	24
2.4.5 Behavior Rating Instrument for Autistic and Other Atypical Children.....	25
2.4.6 Serlin Kinesthetic Imagery Profile.....	26
2.4.7 Functional Assessment of Movement and Perception.....	27
2.4.8 Action Profile.....	28
2.4.9 Espenak Movement Diagnosis Tests.....	29
2.5 Gap Analysis.....	31
3. METHODOLOGY.....	35

3.1 Design.....	35
3.2 Subjects.....	36
3.3 Instrumentation.....	38
3.4 Procedures.....	40
3.5 Data Collection.....	40
3.6 Data Analysis.....	40
3.7 Operational Definitions and Variables.....	42
4. RESULTS.....	44
4.1 Overview.....	44
4.2 Explanation of Survey Responses.....	44
4.3 Demographic Information.....	45
4.3.1 Background Information of Respondents.....	45
4.3.2 Description of Respondents Clinical Service.....	49
4.3.3 Current Clinical Work.....	51
4.3.4 Clinical DMT Assessment.....	54
4.4 Qualitative Findings.....	59
4.5 Major Findings.....	62
5. DISCUSSION.....	69
5.1 Overview.....	69
5.2 Description of Findings.....	70
5.2.1 Clinical Service Description.....	70
5.2.2 Clinical DMT Assessment.....	72
5.3 Limitations.....	74

5.4 Implications for Future Research.....	75
6. SUMMARY AND CONCLUSIONS.....	77
REFERENCES.....	80
APPENDIX A: Initial Survey Invitation.....	86
APPENDIX B: Initial Email Survey Invitation ListServe Posting.....	87
APPENDIX C: Follow-Up Reminder for Survey—ListServe Posting.....	88
APPENDIX D: Survey.....	89
APPENDIX E: Anonymity.....	95
APPENDIX F: Item 6 “Other” Responses “What clinical population do you MAINLY work with”.....	98
APPENDIX G: Item 8 “Other” Responses “List the most common diagnoses of this population”.....	99
APPENDIX H: Item 9 “Please Explain” Responses “Do you assess your patients”.....	100
APPENDIX I: Item 10 “Other” Responses “Aspects that are most important to consider when assessing patients”.....	101
APPENDIX J: Item 11 “Please Elaborate” Responses “At what point in the therapy process do you assess”.....	102
APPENDIX K: Item 14 Responses “What informal methods do you use”.....	106
APPENDIX L: Item 15 “Example” Responses “Aspects of movement MAINLY focused on when assessing patients”.....	108
APPENDIX M: Item 16 “Other” Responses “Employment of published DMT-related assessment tools in their entirety”.....	117
APPENDIX N: Item 18 Responses “What components are used in creating individually- developed tool”.....	118
APPENDIX O: Item 19 Responses “How the individually-developed assessment tool is used”.....	120
APPENDIX P: Item 20 Responses “Other information important in assessment	

process”	124
APPENDIX Q: Accredited DMT Programs—Assessment Courses.....	127

LIST OF FIGURES

1. Respondents work in a clinical setting.....	46
2. Institution where respondents completed their master's in dance/movement therapy.....	47
3. Highest DMT credential for respondents.....	48
4. The year respondents finished their training and received a DMT Credential.....	49
5. The main clinical population focused on in respondents' clinical setting.....	50
6. Length of time respondents have worked in their clinical setting.....	51
7. Most common diagnosis in clinical setting.....	52
8. Second most common diagnosis in clinical setting.....	53
9. Third most common diagnosis in clinical setting.....	54
10. Whether respondents perform clinical assessments.....	55
11. Whether respondents use mostly formal or informal methods of assessment.....	57
12. Whether respondents use individually-developed assessment tools.....	59
13. Clinical assessment related to time in setting.....	62
14. Time in setting compared to assessment method used (graph).....	65
15. Time in setting related to assessment method used (chart).....	66
16. Formal or informal methods of assessment.....	67

LIST OF TABLES

1. Formal methods of assessment.....	58
2. Age population related to use of individually-developed tools.....	68

ABSTRACT

Assessment in dance/movement therapy practice: A state of the field survey

Megan Powell

Sharon W. Goodill, PhD.

The specific objective of this study was to survey dance/movement therapists and how they assess their client's psychosocial functioning in the context of their clinical practices. The problem that was addressed is the insufficient understanding of how patients are being assessed throughout the field of dance/movement therapy (DMT). The ambiguity regarding the use of assessment tools creates difficulties in recognizing how the field is sufficiently or insufficiently understanding patients.

It is important to address this problem because assessment is integral to creating a baseline for treatment and determining the direction in which therapy should progress. In addition, there are ethical implications with regards to standards of practice. In DMT, as in all health care fields, it is necessary for practitioners to know what assessment methods their colleagues are using in order to engage in evidence-based practice.

This study consisted of a web-based survey of dance/movement therapists currently working in the field. The survey addressed aspects of their clinical work regarding background information, a clinical service description, and clinical DMT assessment information. Dance/movement therapists throughout the world, 1,025 potential respondents, were invited to respond to this survey. There were 62 survey responses. The majority of respondents reported that they assess their patients and do so through an ongoing process. In addition, the majority of respondents reported that they use formal assessment methods as opposed to informal means. The results of this study suggest that respondents may have had an unclear perception of the need for systematic

assessment as well as what this should entail. Because there is little research validating the existing assessment tools, as well as the great deal of time necessary to complete many of these instruments, the field of DMT is currently without a standardized assessment process. This author submits that without this, the growth and validity of the field are compromised and steps should be taken to address this problem as the field continues to mature.

CHAPTER 1: INTRODUCTION

The overall aim of this study was to describe the ways in which dance/movement therapists assess their patients. The specific objective of this study was to survey dance/movement therapists as to how they assess their clients' psychosocial functioning in the context of their clinical practices. The problem that was addressed is the insufficient understanding of how patients are being assessed throughout the field of dance/movement therapy. The ambiguity regarding the use of assessment tools creates difficulties in recognizing how the field is sufficiently or insufficiently understanding patients. It is important to address this problem because assessment is integral to creating a baseline for treatment, determining the directions in which therapy should progress, and creating treatment plans. (Sandel, Chaiklin, & Lohn, 1993)

Findings from this survey will allow individuals to see how other clinicians are using assessment methods in order to create a standard of practice. They will also aid in advancements in training and continuing education programs, and provide pilot data to inform further research on this matter. It is vital to contact professionals working in the field in order to understand what methods of assessment are being used at the present time.

The research design used the survey method. Specifically, this was a web-based survey of dance/movement therapists currently working in the field. The survey addressed aspects of their clinical work including, the populations with whom they work, whether they assess their patients, whether they use formal or informal methods, what formal training they received, and where they studied DMT. Professionally credentialed dance/movement therapists were invited to respond to a survey in order to gain an

understanding of the assessment tools that are being utilized. Roughly 900 credentialed professional dance/movement therapists were contacted in the hope that the sample size would be large enough to accommodate a 30% response rate and have a sufficient final sample.

Assessment is one of the defining factors that has enabled the field of DMT to gain respect in its ability to understand psychological processes. (Cruz, 2006)

Throughout the field's development, a number of pioneers have realized that in order to create validity for DMT as a profession, it was necessary to properly assess client movement. (Levy, 1988) Therefore, assessment measures were created that have launched DMT into the growing field it is today. In the early 1900's, Rudolph Laban and Warren Lamb developed the Effort/Shape system which has remained at the core of how dance/movement therapists assess the quality of patients' movements. This system of notating movement offered therapists a language with which to identify what they were seeing. Later, theorists such as Marion North and Judith Kestenberg expanded upon these ideas to create further assessment measures that focused on personality traits and developmental patterns, respectively. (Levy, 1988)

In order to acquire an understanding of the how assessment is currently being used within the field of DMT, it is important to develop a consistent definition. Assessment focuses on the present and ongoing status of a client/patient. (Bruscia, 1988)

The understanding of patient behavior is the most important aspect of assessment, which differs from both evaluation and treatment. Whereas assessment is a formative process and is most crucial in the beginning stages of therapy, it has the potential to progress throughout therapy in order gain a sense of a patient's ongoing development.

Furthermore, the purposes of evaluation and treatment also contrast in that treatment is aimed at inducing a change, whereas evaluation, a more summative process, determines whether a change has actually occurred. (Bruscia, 1988)

CHAPTER 2: LITERATURE REVIEW

2.1 Overview

The first section of this review of literature explores how the use of assessment is reported within the field of dance/movement therapy (DMT). Key aspects of current literature and studies will be presented in order to create an understanding of how dance/movement therapists discuss the assessment of patients and what impact this has on the field. The second section includes a broader overview of how assessment is utilized throughout the mental health field as a whole. This information is critical to this study in that applied mental health practices can be compared to the role that assessment plays within the specified field of DMT. The third section explores literature that informs the field of DMT on assessment. This information offers insight into aspects that are unique to the study of DMT and should be considered in the application of assessment. The fourth section offers examples of published DMT assessment tools. These assessment tools are presented and described to create an image of how assessment may be conducted with DMT clients. Finally, a gap analysis is presented to delineate what is missing in current literature on DMT assessment, which this study aims to address.

2.2 Role of Assessment in Clinical Practice

2.2.1 Dance/Movement Therapy Scope

Any assessment should uphold certain clinical standards in order for it to be effective. These include having clearly defined objectives, the presence of a qualified therapist, uniqueness of clinical advantages, effective methods of data collection, reliable

data, adherence to ethical standards, and the ability to lead to valid conclusions. (Bruscia, 1988) These aspects of assessment should be present for the tool to produce objective findings pertaining to a client. Bruscia defines assessment as “the part of the therapy process concerned with understanding a client, his condition, and therapeutic needs and remains an ongoing process throughout therapy.” (Bruscia, 1988, p. 5) This clinical definition of assessment and the thorough procedures that it implies are important to consider in the discipline of DMT.

There are certain criteria established through the Ethical Standards of Practice of the American Dance Therapy Association (ADTA). The use of assessment is recommended, but not mandated, within this code, which explains its purposes and how it can be used within a clinical setting. According to the Ethical Standards of Practice:

PRINCIPLE 11: EVALUATION/ASSESSMENT: For the purposes of diagnosis, treatment planning, and/or research, a dance/movement therapist may engage in assessment of clients utilizing only those instruments and techniques for which he or she has been trained.

A. Assessment instruments and assessment practices may include verbal or nonverbal techniques, or a combination of both. (Ethical Standards of Practice, American Dance Therapy Association, 2005)

This information regarding assessment and evaluation explains that the assessment process is something that may occur within a clinical setting. In terms of how an assessment should be administered within a clinical context, the Code of Ethics ascertains that it can be either verbal or nonverbal.

More specific to its application within the field of DMT, assessment is unique in that therapists use observations of clients’ movement in order to assess and to create interventions. (Cruz & Koch, 2004) As the field was developing in the 1940’s, the

practice of DMT was not widely accepted and evidence-based assessment procedures had not yet been established. Therefore, clinicians had only their intuition to rely upon and had to work to develop skills such as observation, interpretation and ideas about how dance elements could be manipulated to best serve patients. (Cruz, 2006)

Marian Chace, a pioneer of DMT, believed that all individuals have an innate motivation to move in the direction of health when given the opportunity to do so. Therefore, through observation, assessment, and structuring appropriate movement interventions, individuals can learn skills to aid in this transition toward health. Chace practiced from the philosophy that through understanding the normal process of development, the dance/movement therapist can analyze areas of dysfunction. Furthermore, the therapist can also assess defenses that the client uses to cope in order to choose proper interventions that will direct him/her toward health. Chace chose to describe what she saw through the words of the body and dance and not through words of other disciplines. (Fischer & Chaiklin, 1993)

According to Bruscia, the creative arts therapies are unique in their capacities to provoke inner processes through artistic media that can be specifically seen through the particular art form. Therefore, each modality can only assess through very specific methods. (Bruscia, 1988) Zwerling (1989) asserted that there are two distinct aspects of the creative arts therapies that distinguish them from verbal therapies. These include the way in which emotional, as opposed to cognitive processes are elicited as well as the fact that they are reality-based and provoke a more authentic link to a patient's experience. The processes that the therapist wishes to evoke are more directly and genuinely brought

forth through the artistic medium. (Zwerling) These processes are critical to a discussion of how assessment is utilized within the creative arts therapies.

There are basic assumptions involved in the assessment process for creative arts therapies. It is the belief of the therapist that art is intrinsic to being human. Regardless of development, structure, and level of talent or training, everyone has the capacity to appreciate the arts. Every art modality involves the whole person, including sensorimotor, perceptual, cognitive, emotional, social, and spiritual components throughout varying levels of consciousness. The creative expression is considered a reflection of certain dimensions of human experience. In addition, growth in the art form is a sign of growth in other aspects of functioning. (Bruscia, 1988)

Specific to assessments done in DMT, the environment in which the assessment is taking place is important to the observed results. Depending on whether the assessment is taking place in a research or clinical context plays a role in what the client feels and displays through movement. (Cruz, 2006) It is important to know whether a person is reacting from an inner impulse or from their environment. These effects must be acknowledged so that appropriate adjustments can be made. Otherwise, they may influence the client's movement and skew the assessment. Furthermore, the observer can be heavily influenced by the environment as well. The observational setting has the capacity to influence one's psychological state, the conditions for observation, and the behavior of the presenting patient. (McCoubrey, 1987) Therefore, one must take into consideration how the environment is affecting both the mover and the observer throughout the assessment process.

The way in which a dance/movement therapist observes his/her client creates room for error often with regards to what aspects of movement are selected for attention. Part of knowing one's personal identity as a dance/movement therapist includes the awareness of how certain theoretical frameworks impact clinical assessment and judgment. Therefore, based on the therapist's adherence to a theoretical perspective, the dance/movement therapist may be more inclined to pick up certain aspects of the movement and neglect others. (Goodill & Leatherbee, 1984) This impact in theoretical preferences could compromise the therapist's ability to perceive what is actually happening within a person's movement. Because people are multifaceted, they cannot be defined by aspects of one particular theory. It is important for the dance/movement therapist to pull from a number of theoretical frameworks and "perceive all verbal and nonverbal information on a content and process level simultaneously." (Goodill & Leatherbee, 1984, p. 3)

It is also important to address possible observer preferences, depending on what the client is being compared against. (Cruz, 2006) There is a subjective component that is present throughout observation as a result of a clinician's individual perception. Perception can be made up of a number of things, including selectivity, prior knowledge, and interpretation. Humans are used to adapting what they see to what they expect to see. (Cruz & Koch, 2004) This can influence how movement is perceived. Cassirer (1969) explains that perception is:

an ordering, synthesizing activity, on the basis of which perceptual objectivity is derived and defined. It is a process whereby an 'object' becomes located within the spatial field and 'stands out from' its background. In this process what is 'given' becomes spatially located, differentiated, and 'noticed'. It is here that the distinction between 'reality' and 'appearance' emerges. (Cassirer, p. 279)

An individual's way of perceiving something that is observed is unique to the individual and thus creates room for error in the reliability of results. McCoubrey (1987) explains that, according to Effort theory, observing Effort qualities, including Space, Weight, Time, and Flow, invites error in interobserver reliability. Because Effort elements measure Inner Attitudes, it is difficult for the observer to deny the provocation of their own Inner Attitudes. McCoubrey asserts that observers must prepare themselves to perform reliable observations by practicing a "standard reference of Effort experience that is shared by other observers." (1987, p. 3)

Intersubjectivity is an important aspect to consider in obtaining objective and valid observations. McCoubrey (1987) explains that the relationship shared by the infant and mother is the child's first experience with developing intersubjectivity. Through learning how to sense the patterns of bodily tension and movement of others, the child learns to perceive meaningfully and to empathize. Furthermore, McCoubrey asserts,

The basis for agreement among observers is that we all live in moving bodies which share the same potentialities and limitations. It is the application of a consistent theory and method of analysis to a universal phenomenon, that itself provides a 'built in' frame of reference in the observers' common and articulated experience of moving, that makes it possible to achieve interobserver reliability. (1987, p. 5)

After movement is observed and perceived, translating these observations into language creates room for error in the assessment process. Because movement is most heavily focused on in DMT, language and verbalizations are used as an adjunct to what is being represented in the movement. Dance/movement therapists have been accused of being too vague in their use of language and of employing certain terms that have little meaning to the other disciplines. (Sandel, Chaiklin, & Lohn, 1993) Some

dance/movement therapists believe that language provides a limited vocabulary for what we see in movement, therefore, it is difficult to adequately express what the movement represents through language. (Cruz & Koch, 2004)

Dance/movement therapists use movement as a means of relating to patients and transitioning them toward health. Fischer and Chaiklin (1993) explain that because the patient is presenting developmental inadequacies in movement behaviors, the dance/movement therapist must respond in movement to help the client work through these stages of development and experience healthier movement patterns. Furthermore, Chace believed that the therapist's role is to assess the patient and respond to the movement behaviors in a meaningful way. She felt that it was important to describe what she saw using the language of the body and dance as opposed to that of other disciplines. (Fischer & Chaiklin, 1993) Because the body is the central means of communication, the vocabulary of the body is used to express what is occurring. However, there is no way to validate what a therapist experiences through his/her own emotions. Marian Chace asserted:

A considerable amount of attention is being given to the nonverbal forms of communication, often with very little understanding of the difficulty in the translation of these happenings into verbal terms. More is lost in this translation than in the translation of word symbols from one verbal language to another. (Fisher, Chaiklin & Lohn, 1993, p. 332)

Language is utilized as a way to translate what is occurring in the movement, which oftentimes does not represent the actual movement.

Rudolf Laban's system for defining movement, known as Laban Movement Analysis (LMA), provided clinicians with a way to categorize movement and offer

specific names to certain movement qualities. In the development of his movement language, Laban discovered that movement could be described as it applied to spatial patterning (Shape) or its rhythm and accent (Effort). For the purposes of identifying where and how people move, Laban created this system which is made up of symbols that describe what is occurring in the movement based on these spatial and rhythmic components. North, who worked with Laban, explained LMA as:

not only an objective, nonjudgemental system to scientifically describe movement behavior, but also as a way to correlate various movement tendencies described in LMA terminology with personality characteristics, including the strength, potential, and limitations of the personality. (Levy, 1988, p. 152)

Through creating universal terms for movement, clinicians are able to more accurately communicate what they see.

Laban's system was crucial in the development of a universal method of observation among dance/movement therapists. (Cruz, 2006) This observation method helped dance/movement therapists in developing a language that would aid them in unifying how patients are assessed in the field. (North, 1972) North explains that, "Movement, as revealed in our gestures, unconscious movements, body carriage and our working actions, is always 'ourselves'. It always speaks honestly..." (North, 1972, p. 6) Therefore, through LMA, dance/movement therapists are able to find a language to draw out the true meaning of what people are portraying through their movement to engage in discussions of movement features and to carry out research on these characteristics.

In addition to language, the way in which one observes movement may leave room for error as well. However, observation used in DMT is considered scientific because it differs from everyday observations in that it is maintaining a level of validity

and reliability as well as being systematic. (Cruz & Koch, 2004) Systematic observations can be shown in a number of ways. First, structured observation is done with predefined categories, whereas unstructured observation is done without predefined categories. Further classifications include overt or covert observations. This explains whether the observed person knows about the observation, mediated or nonmediated. It also describes whether he or she is observed through videotape, and whether it is a laboratory or field observation, depending on whether the observation takes place in a controlled or natural setting. (Cruz & Koch, 2004)

Observational coding systems can also be used to help determine what is occurring in the movement. A coding system should consider the context, units of time, what types of categories and how many categories are included. (Cruz & Koch, 2004) These considerations are important because they allow the observer to efficiently dictate what is seen through the movement as well as valuable contextual information.

In addition, ethical considerations are vastly important throughout the assessment process. The therapist should not draw conclusions that are beyond his/her ability to do so, given the knowledge of the modality being used. It is necessary that a person should be properly trained in the field in which the type of assessment that is being used has originated. The rights of the client must be upheld throughout the assessment process, whereas the client is informed appropriately of certain procedures. (Bruscia, 1988)

2.2.2 Mental Health Scope

It is important to determine how assessment is used throughout the mental health field, as a whole, in order to gain a sense of how the field of DMT is meeting standards.

Clinicians use a number of assessment methods within specific mental health fields.

Anderson (1999) explains that many of the assessment tools used throughout the mental health field are nomothetic in nature, in that they strive to categorize patients into diagnostic fields. The author proposes functional assessments as an alternative for these nomothetic ones. Functional assessments are explained as the environmental variables that are created when behavior is used as a function. However, Kazdin argues that no matter what form of assessment is utilized; it must be systematic in order for it to be effective. According to Kazdin (2006), a clinician must execute certain steps for an assessment to be systematic. First, he/she must closely monitor the effects of a treatment to determine the ongoing course of treatment. Not every method of treatment is beneficial in every therapeutic situation. Second, clinical judgment must remain at the core of all assessment procedures. Systematic evaluation is intended to support clinical judgment and should be trusted and utilized. Third, because a client's progression of treatment may change throughout the course of therapy, the complexity of a case must constantly be evaluated as therapy advances. Lastly, it is important that specific patient needs do not get generalized to different populations with their own unique needs in treatment.

According to the theory of Behavior Therapy, assessment focuses on understanding an individual's problem, developing treatment plans, and noting measurable change. Here, assessment is executed according to categories of stimulus, organism, response, and consequence which relate to the person's level of functioning. Once this information is attained, the therapist can determine a course of treatment. Antony and Roemer (2003) explain that an assessment in Behavior Therapy should

identify target behaviors that will be addressed throughout therapy, and alternative behaviors that can help to replace these target behaviors. In addition, the assessment should be used in developing a treatment plan that helps to understand the client's triggers and reinforcing consequences. (Antony & Roemer, 2003)

In recent years, clinicians have strayed from using functional assessment methods and have begun to use symptom-focused assessments, where the goal is to measure the presence, absence and severity of a symptom. Because insurance companies pay for therapy according to diagnostic criteria, the field of Behavior Therapy has become more focused on these diagnostic components of assessment. The behavioral perspective stresses a thorough assessment procedure where therapists gather symptomatic information as well as evaluate individual characteristics. (Antony & Roemer, 2003)

Educational settings have long been looking toward ways to improve students' ability to learn. Formative assessment is one way in which researchers hope to implement this necessary change. Cowie and Bell explain formative assessment as "the process used by teachers and students to recognize and respond to student learning in order to enhance that learning, during the learning." (1999, p. 101) Summative assessment, as opposed to formative, has long been the general method used to assess children's learning. Summative assessment, as defined by Garrison and Ehringhaus (1999) "are given periodically to determine at a particular point in time what students know and do not know." (p. 2)

These researchers came up with a model that focused on five key aspects necessary in a formative assessment. First, this model consisted of both planned and interactive assessment approaches. Formative assessment is explained as a complex and

skilled task. This model stresses the purpose of both planned and interactive assessments. The researchers explain:

The purpose of planned formative assessment was perceived as obtaining information from the whole class about progress in learning the science as specified in the curriculum to inform the teaching. The purpose of interactive formative assessment was perceived as mediating in the learning of individual students with respect to science, personal and social learning. (Cowie & Bell, 1999, p. 113)

Next, the model stresses the action taken in response to performing planned or interactive assessments. The final key element explains the importance of including research data into existing knowledge of formative assessment. (Cowie & Bell, 1999)

2.3 Research to Inform DMT Assessment

Validity with regards to assessment measures is essential in order to produce accurate findings. The validity of an assessment measure is the extent to which it gives the kind of insight about the client that it promises. (Bruscia, 1988, p. 9) Validity is defined as the degree to which an observation scale measures what it is supposed to measure. Reliability is defined as the consistency or accuracy of the scores that result from the observation/measurement process. When using observation for clinical and research purposes, validity is actually more important than reliability because while reliability is necessary, it is not sufficient for creating the validity of observations. (Cruz & Koch, 2004)

More specifically, content validity in psychological assessment is critical in creating assessment tools from which clinical inferences can be drawn. Haynes, Richard, and Kubany explain content validity as, “the degree to which elements of an assessment instrument are relevant to the representativeness of the targeted construct of a particular

assessment purpose.” (1995, p. 239) For an assessment procedure to test what it is supposed to test, definitions must be clear and consistent. Without these clear definition boundaries, the assessment may be representing something other than the observed construct. (Haynes, Richard & Kubany, 1995) The American Psychological Association and the American Educational Research Association identified validity as an important element of testing standards and guidelines. (Cruz & Koch, 2004) Validity is not an established or general attribute of an instrument or observation, but must be carefully tested for in order to ensure its applicability to a particular field of study. (Cruz & Koch, 2004)

Content validity involves determining how representative an assessment method is of the subject area that is being measured. Components of content validity cannot be measured, but can only be estimated in a subjective way. Therefore, content validity alone, is not sufficient for an observation tool. Determining content validity consists of defining the constructs that are attempting to be measured through the assessment tool. (Cruz & Koch, 2004)

The field of DMT faces challenges in terms of gaining validity as an evidence-based practice. This is due, in part, to the fact that assessment within the field relies upon the analysis of nonverbal movement; therefore, some of what is observed is lost through the translation of the therapist and their word choice. (Sandel, Chaiklin, & Lohn, 1993) Because movement observation can be highly subjective, dance/movement therapists work hard to validate their observations in order to create validity throughout the field in terms of what is seen through the movement. “Movement information must have a

system of observation and notation to be understood and communicated between therapists and for research purposes.” (Westbrook & Sing, 1988, p. 37)

There are a number of factors to consider when creating an assessment tool that will provide trustworthy results. Because the constructs that are being tested may change over time, the results of an existing assessment measure could become unstable.

Assessment tools need to be more universally useful in their ability to produce reliable findings over time. In order to assure that all assessment tools are finding reliable results and are consistent over time, they must be tested for reliability before their results are trusted. An example of a test for validity in DMT can be seen through a study that attempted to support the validity of an assessment tool known as the Movement Psychodiagnostic Inventory (MPI), which assesses involuntary movement disorders. This study concluded that the MPI may make more specific distinctions of involuntary movement disorders that are associated with certain types of psychopathology. (Cruz, 1995) Therefore, when used within the field of DMT, the MPI can be trusted to find distinctions within patient movement.

Because the nature of each assessment situation is unique, individual considerations must be made with regards to validity. Haynes, Richard & Kubany (1995) assert:

Differences among assessment methods in the applicability of the various content validity elements are also influenced by the underlying assumptions of the assessment paradigm. For example, situational factors are frequently of interest in behavioral assessment. Therefore, the representativeness and relevance of situational factors are particularly important considerations in behavioral assessment. (p. 244)

In order to create representative assessment tools, these authors suggest clearly defining construct domains and subjecting them to content validation before further developing an assessment measure. (Haynes, Richard & Kubany, 1995)

Criterion validity addresses the issue of how representative an assessment measure is, but here actual data is necessary. This is because it is essential to explain an empirical or data-based connection between what is observed and some other criterion of behavior. Construct validity is based on theory since it is used to determine the extent to which a measure truly assesses an individual's status on a given construct. (Cruz & Koch, 2004) Different types of evidence that can be used to argue for construct validity include showing how the results of a scale fit with a specific theory, measuring movement features before and after treatment to determine amount of change, and demonstrating differences between groups that should have differences on a scale. (Cruz & Koch, 2004)

In addition to validity, reliability can simply be defined as a consistency between scores. Furthermore, it can be explained as the amount of difference between the "true" score and the observed score. The amount of difference between these two scores determines how reliable an assessment method is. This difference is known as measurement error and can be created by a great range of things. (Cruz & Koch, 2004)

Inter-rater agreement is the degree to which different observers agree in their observations and is a critical component to a systematic form of assessment. This indicates agreement of scores, interpretations, conclusions, and diagnostic inferences made on the basis of scores. (Cruz & Koch, 2004) Overall, scientific observation differs from everyday observations in its ability to be replicated. This means that someone else

observing the same thing will come up with concurrent conclusions. (Cruz & Koch, 2004)

2.4 Examples of DMT Assessment Instruments

2.4.1 Movement Psychodiagnostic Inventory

The Movement Psychodiagnostic Inventory (MPI) is an assessment tool that determines severe psychopathology seen through body movement. (Davis, 1997) This is an influential assessment method used in the field of DMT that allows movement therapists to base observations of clients on aspects of the MPI in determining presence of psychopathology. (Davis, 1997) Developed by Martha Davis, this assessment tool is based on the work of Irmgard Bartenieff whose work is heavily influenced by Laban Movement Analysis. She trained Davis to record observations and translate them into a reliable coding system, which came to be known as the MPI. (Davis, Lausberg, Cruz, et al., 2007) Out of this work came an inventory of 60 movement patterns which is not limited to assessing severe psychopathology. Davis, et al. (2007) asserts, “Potentially, the MPI analysis could generate discoveries about the nature of various diagnostic conditions and relationships between clinical states and medication effects.” (p. 120) The inventory is divided into two parts, with Part 1 consisting of the “Action Inventory” that deals with aspects of conversational behavior and Part 2 consisting of the qualitative components of movement that may be apparent in varied actions. (Davis, Lausberg, Cruz, et al., 2007)

Davis and her colleagues implemented a number of studies to test the validity of the MPI in clinical situations. Initially, MPI assessments were completed on 52

American and Swedish patients diagnosed with schizophrenia, narcissistic personality disorder, or borderline personality disorder. In reference to the findings, Davis, et al. (2007) states:

In this sense the MPI analysis supports recent views of the nature of severe psychopathology and differential diagnosis that reject univariate differences in favor of a more complex model. What distinguished the severity of psychopathology was not a single MPI category, but how the categories clustered. (p. 123)

In other work with the same information, these researchers found that the MPI was able to make finer distinctions regarding motor disorganization than other assessment tools. This could have diagnostic and therapeutic relevance in the assessment of psychopathology. (Davis, et al., 2007)

2.4.2 Nonverbal Assessment of Family Systems

The Nonverbal Assessment of Family Systems (NVAFS) was developed by Dulicai (1977) in order to uncover the nonverbal qualities of behavior within family systems. This scale incorporates kinesics factors and Laban's effort/shape analysis of body movement, which was then modified for family processes. Dulicai explained how conflicts that arise through family functioning could be detected through nonverbal behavior and its points of deviation. In a preliminary study, Dulicai aimed to look at the nonverbal behavior of family interactions in determining conflicting messages that were being communicated throughout a family system.

In this study, two groups of four families were observed over an 18-month period of time and separated into two groups depending on their degree of perceived familial conflict. The first group had never sought psychiatric assistance and felt that there were

no prominent difficulties in their family functioning. In the second group, the family was seeking psychiatric help for a presenting patient within the family unit. Findings from the NVAFS supported the hypothesis that conflicts in family functioning could be detected through nonverbal behavior. The study concluded that pattern analysis of behavior may yield predictive information regarding kinds of behavior that may be expected to occur in familial interactions. (Dulicai, 1977)

2.4.3 Kestenberg Movement Profile

The Kestenberg Movement Profile (KMP) is an assessment tool that enables dance/movement therapists to observe developmental qualities through movement observation. The KMP was created by Dr. Judith Kestenberg, a psychiatrist and psychoanalyst who was interested in movement and how it manifests in normal developing children and their parents. (Hastie, 2006) This assessment was tool based on the work of Laban's and Lamb's Effort/Shape system and helps to organize and notate movement qualities in a developmental perspective, unique to the KMP. (Hastie, 2006) The KMP can be used to assess the movement of infants, children, and adults. Hastie explains the profile and its importance in DMT for observing normal development, so that one can better understand prevention of pathology through movement. (Hastie, 2006)

There are two systems within this profile. The first, System I, is the Tension-flow-Effort system, which evaluates the feeling and substance of movement patterns. (Hastie, 2006) System II, Shape-flow-Shaping system, evaluates the shape or structure of movement as well as its relational development. Both systems are structured based on developmental progression, beginning with what is typical of a fetus/newborn and ending

with what is typical for an adult. These patterns build on top of one another so that by the time a person reaches adulthood, they possess all of the movement patterns developed from birth. Hastie (2006) also explains that the KMP aids in understanding movement that occurs at different stages of development.

There are a number of ways to utilize the KMP for assessment purposes. These include, creating complete profiles of an individual, doing pre- and post-profiles to evaluate the progress of treatment, and comparing profiles against one another to better understand parent/child relationships. According to Hastie, Kestenberg believed that it was most beneficial to do complete profiles in order to create accurate and meaningful assessments. (Hastie, 2006)

Research done regarding the KMP has focused on areas including personality assessment, autism spectrum disorders, infant mental health, and parent-infant dyads. Throughout this research, the KMP has been shown to be an effective assessment tool in delineating aspects of nonverbal behavior within each category. Existing personality assessment instruments, such as the Rorschach, and the Minnesota Multiphasic Personality Inventory (MMPI), identify similar components of personality as the KMP. The information yielded from the KMP is useful in determining aspects of personality and may serve to further validate the KMP as an assessment measure. (Birklein & Sossin, 2007)

The KMP may have strong implications for determining early diagnosis for autism. Further research comparing the KMP to existing appraisals may generate findings that prove the KMP to be a worthy assessment measure for this population. Birklein and Sossin (2007) assert, "It is hoped that the KMP can contribute to initial

assessment, but even more so, to a framing of nonverbal treatment interventions, and to appraisal of ongoing changes over time.” (p. 107)

In addition to autism, the KMP takes into account aspects focused on within the field of infant mental health through movement observation. These include self-regulation, motor planning, responses to sensations, sensory-seeking behaviors, shared-attention, affective engagement, reciprocity, and shared intentions. The KMP provides a wealth of opportunities to identify developmental factors within these behavioral domains. It has been useful in determining aspects of normal and maladaptive developmental movement patterns. (Birklein & Sossin, 2007)

Because the KMP is made up of two major systems that assess differing aspects of movement, Koch (2007) implemented a number of consecutive studies to test for validity. These six tests for validity targeted specific systems of the KMP to achieve a more accurate understanding of validity within the KMP. The first two studies addressed the effects of rhythms, more specifically indulgent and fighting, on affect, cognition, and attitudes. Tests 3 and 4 focus on rhythms in conjunction with approach and avoidance movement behaviors. Study 5 looked at the effects of growing and shrinking movements on affect, cognition, and attitudes. Finally, study 6 tested Efforts against either approach or avoidance movements. General results from these tests show that movement rhythms and shape had an influence on affect and attitudes, but not on cognition. Studies on rhythms consistently showed effects on affect, while shape induced a greater influence on attitudes. (Koch, 2007)

2.4.4 Psychiatric Movement Assessment Scale

Psychiatric Movement Assessment Scale (PSAMS) was developed by Westbrook and Sing to ensure the assessment process was more manageable. Because previous assessment tools involved lengthy procedures as well as extensive training, the researchers were sure to take this into consideration when creating the PSAMS. (Westbrook & Sing, 1988) This assessment tool was created to focus on developmental aspects in order to relay information in an objective way, assess individual patients after attending group situations, offer diagnostic information according to developmental considerations, and offer information on initial assessment as well as progressive features. (Westbrook & Sing, 1988)

The authors created a questionnaire to gather information from dance/movement therapists regarding what they felt were important components of an assessment measure. The PSAMS includes two sections, the Form and the Chart. The Form includes five movement categories and is used by the dance/movement therapist to record the patient's movement qualities. The Chart integrates information gathered from the Form as well as the developmental framework. (Westbrook & Sing, 1988) In developing the scale, the authors sent questionnaires to dance/movement therapist asking questions regarding existing assessment tools and what aspects of movement were assessed depending on the presenting diagnosis. (Westbrook & Sing, 1988)

Heavily influenced by Mahler's phases of development, the PSAMS assesses these phases in how they are represented through movement. Clinical applications for the PSAMS include its ability to be translated into developmental and psychological terms for other professionals, derived findings can be useful in determining a patient's level of

functioning, and it can be used to track progress throughout the course of treatment.

(Westbrook & Sing, 1988)

2.4.5 Behavior Rating Instrument for Autistic and Other Atypical Children

The Behavior Rating Instrument for Autistic and Other Atypical Children (BRIAAC) is designed to evaluate a broad range of levels of functioning within the autistic spectrum. This instrument focuses on eight areas of behavior, including relationship, communication, drive for mastery, vocalization and expressive speech, sound and speech reception, social responsiveness, and body movement and psychobiological development. The child is observed within familiar settings, including the home, classroom, or institutional setting, and is scored based on these observations.

(Ruttenberg, et al., 1976)

The values of the BRIAAC include its successful use with children who appear to be “untestable” through other means of testing that require the child’s cooperation through administered tasks. Because the BRIAAC is executed through observation, cooperation is not required on behalf of the child. This tool can also determine a child’s developmental sequence of improvement or regression in observed behaviors. Once a baseline level of functioning is determined, the BRIAAC can then be further administered at a later date to determine the level of success of a particular treatment.

(Ruttenberg, et al., 1976)

The BRIAAC offers clinical implications for practice. It has shown to be successful in broadening the understanding of disorders such as autism for professionals working with the child. Ruttenberg and colleagues asserted, “In teaching and training,

the study and use of the BRIAAC has proven to be a valuable tool for sensitizing both observers and those working with autistic and atypical children to the varieties and subtle differences in atypical behavior.” (Ruttenberg, et al., p. 4, 1976) Furthermore, information gained from the BRIAAC can be used in treatment planning for individualized children. More specifically, information gathered from this kind of assessment has aided in differentiating autism from other disorders such as mental retardation or brain damage. (Ruttenberg, et al., 1976)

2.4.6 Serlin Kinesthetic Imagery Profile

After examining the existing scales concerning body image for breast cancer patients, Serlin (Unpublished manuscript) found that many of them were inadequate in determining the accuracy of one’s body image. Therefore, she created a unique profile that would more effectively evaluate body image through movement. The profile, Serlin Kinesthetic Imagery Profile (SKIP), is composed of two parts. The first part was developed through a phenomenological investigation of women who had taken part in DMT over a period of time. The subjects were asked to report their experience of change over time in DMT. Two years worth of interviews were collected from the women, focusing on the experience of change in relation to their bodies. After a content analysis was done on the collected information, 39 items were derived and a self-report section was created. This includes statements listed under four categories, including Body, Emotions, Spirituality, and Self-Esteem and Self-Care. Participants select choices for how much or how little they agree with the listed statements. (Serlin, Unpublished manuscript)

The second part of the profile included the creation of an observation scale based on previously collected items. Labanotation was used in creating a baseline body image profile. From there observers could then track a patient's change over time according to the baseline. In a pilot study, Serlin tested to see if the process of collecting data was feasible for an observer in order to develop a sample profile. Results of the pilot study found that the process was manageable for an observer. Appropriate modifications were made, including omitting categories that were either not significant or too cumbersome for healthcare professionals. (Serlin)

2.4.7 Functional Assessment of Movement and Perception

The Functional Assessment of Movement and Perception (FAMP) was designed specifically to measure severe neurotrauma in relation to DMT. The FAMP was created by Berrol and Katz, et al (1996) in response to a lack of appropriate alternative assessment measures for these purposes. Through the results of this assessment, the authors looked to use the tool as a means of creating therapeutic treatment goals and objectives. Unlike other assessment tools, the FAMP is a domain referenced assessment, as opposed to one based on norms. A domain referenced assessment is explained as one that observes mastery in relation to a task rather than comparing an individual to an expected norm.

The FAMP was used in a project that investigated the effects of DMT on older adults who had sustained neurological insult. Participants were measured based on categories including Total Body Scheme, Spatial Orientation, Perceptual Motor Ability, Range-of-motion, Rhythmic Discrimination, Motor Planning, Timed Motor Activity, and

Delayed Repetition. The authors hypothesized that DMT would improve physical function and social interaction, while decreasing depression. The FAMP was used to assess movement parameters as well as create test reliability and validity for the geriatric population involved in the study. Therapy consisted of two 45 minute DMT sessions over a five month period. Findings suggested that the DMT helped to strongly improve participants functioning in a number of functional areas. (Berrol, Katz, Lombardo, & Ooi, 1996)

2.4.8 Action Profile

Action Profiling is based on Laban's principles of movement analysis and was developed by Warren Lamb and Pamela Ramsden. Today, it is a form of assessment mainly used for management consulting, where business executives are assessed according to movement data. This data is then associated with a certain level of cognitive functioning. (Loman, 1992) Action Profiling is used in observing two-hour interview sessions and looks at six movement categories, including space, time and weight Efforts as well as horizontal, vertical, and sagittal shaping elements. (Winter, 1987)

Action Profiling focuses mainly on integrated body movements, which Lamb refers to as Posture-Gesture Mergers (PGM). Winter (1987) describes PGM's as:

occurring when a partial body movement flows into a whole body postural motion, or vice versa...They give the observer the sense that there is a kind of glue or flow between one movement and the next, as well as between one body part and the whole body. (p. 21)

Lamb's reasoning behind focusing on PGM's was that he found that they offer insight into a person's authentic expression as well as cognitive functioning. Conflict may be represented by a person's inability to integrate postural and gestural movements.

Therefore, Action Profiling looks deeper into a person's ability to make decisions based on the aforementioned movement categories. (Winter, 1987)

In an effort to find Action Profiling to be a reliable source of movement assessment, Winter aimed to achieve inter-observer reliability. Previously, profiles were observed by only one person. Winter had two observers score videos at the same time, with a seven and a half year span of time between the two observations, and with one person observing the subject and another observing a video of the subject. The study found that observer reliability was high for all observation situations. Therefore, Winter could conclude that the Action Profile was reliable both live and from video as well as stable over time. (Winter, 1987)

In a study to test for validity of Action Profiling, Winter (1992) tested motivation for different kinds of cognitive operations against scores on the Myers Briggs Type Indicator (MBTI). When tested against the MBTI, Action Profiling results were consistent with those of the MBTI at a statistically significant level. (Winter, 1992)

2.4.9 Espenak's Movement Diagnosis Tests

This series of tests was developed by Liljan Espenak and aims to identify the repertoire that a patient brings to the therapeutic interaction including emotional content, i.e. Rhythm, tempo, form and space relations. Through years of research, Espenak developed this system of six tests that examine positive and negative aspects of a patient's personality. These tests begin with Emotional Response, which includes Self-Assertion (Body Image). The Self Assertion test contains a muscular test where the patient is asked to walk across the room. This helps to better understand one's ego

strength and self-assertion. The Emotional Response section also includes Improvisations (Emotional State). This test includes a free improvisation where the patient moves to music and a repetitious pattern of movement is revealed. (Espenak, 1989)

The second test looks at Degree of Dynamic Drive (Energy) and looks at the physical and motivational energy that a patient puts forth in completing a task. For this test, the patient is asked to push a large object so that force is exerted. Depending on the amount of force or energy applied, the therapist gains an idea of how hard the patient can be pushed. This test is followed by the third test that looks at Control of Dynamic Drive (Rhythm). Control and organization of time reveal a patient's personal rhythm, which offers a deeper look into the culmination of a person's personality. The breath is the focus of this since it is the most natural indicator of a person's rhythm. (Espenak, 1989)

The fourth test is for Co-ordination (Animal Function). This test investigates a patient's quest for totality through the combination of mental and emotional processes. This is tested for through observation of the movement of a patient's sacrum. As humans learn to walk, coordination develops. As the sacrum is the main contributor to walking, there lies valuable information in how coordination developed in a particular person. This test is followed by the fifth test for Endurance (Frustration Tolerance), where the patient's ability to combine kinesthetic drive with mind control is tested. Among this is attention span, frustration threshold, and stress reactions. By using repetitions of certain movements, the therapist is able to assess a patient's ability to tolerate change, attention span, and a narrowing and widening of focus.

The sixth test is for Physical Courage or Fear and tests the person's capacity to deal with unfamiliar situations involving movement. The therapist will have the patient walk backwards, walk in a circle while leaning into the middle, and perform floor exercises including rolling forwards and backwards on the floor. Through these exercises the therapist can assess the patient's level of anxiety and fear, which translates to how they cope with real life situations.

2.5 Gap Analysis

Through surveying practicing dance/movement therapist, it is possible to gain a state of the field perspective on how assessment is being administered throughout the field of DMT. The results of this study will create a clearer understanding of whether assessment is being performed in a systematic way. Through information gathered from the survey responses, it is possible to make DMT a more evidence-based practice by discerning how the assessment process can be improved.

Through reviewing the literature regarding assessment in DMT, there appears to be a strong need for evidence-based research throughout the field in order to gain respect and validity in clinical work. Recently, there has been a growing emphasis on the need for evidence-based practices within the mental health field as a whole. With advancements in the understanding of certain diagnoses, research must be performed to direct the course of treatment. More importantly, with the burden of health care costs around the world, governments have decided to offer funding to evidence-based practices to ensure the effectiveness of treatment. (Huppert, Fabbro & Barlow, 2006)

Specific to the field of DMT, it is imperative that research be conducted in order to follow the trends of the mental health field. However, there appears to be a dearth of

evidence-generating research. Cruz and Hervey (2001) surveyed 1,178 members of the American Dance Therapy Association to gather their ideas of the importance of research within the field of DMT. A staggering number of clinicians did not partake in research studies; however, most of them agreed that research was an important component in the advancement of the field. Furthermore, the researchers assert:

“It can be argued that the volume of research in DMT may not be keeping up with the demands of ethical practice and healthcare policy. For example, between 1998 and 2000, only three data-based articles were published in the *American Journal of Dance Therapy*.” (Cruz & Hervey, 2001, p. 90)

Therefore, the field of DMT must produce more research in order to be deemed an evidence-based practice and to earn respect throughout healthcare systems.

Clinical assessment, performed throughout any mental health field, is the first step to understanding a patient. It allows a clinician to design interventions, predict future behavior and develop treatment plans, all integral in the successful treatment of clients. (Haynes, Richard & Kubany, 1995) However, Kazdin (2006) explains that the central problem causing the gap between treatment research and clinical practice is the ways of evaluating, or assessing, information in clinical settings. Standardizing assessment methods may appear to be a solution according to controlled research studies, but they fail to appropriately assess across diagnostic populations. (Kazdin, 2006)

Another aspect that is important to consider in discussing standardized assessment is DMT education. According to existing DMT curriculum from accredited schools (Appendix Q), courses containing assessment education differ among educational settings. This means that students are not getting a consistent education regarding how to assess patients. A number of programs contain courses involving strengthening students

ability to observe movement. However, the courses focus on different aspects of assessment, according to the course descriptions. For example, the movement observation and assessment course description for one program explains:

In this course students look at how the mind is expressed through the body. The focus is placed on gathering the basic terms and concepts necessary to cultivate the skill of seeing the body descriptively both in stillness as well as in motion. A range of observation and assessment models specific to dance/movement therapy and body psychotherapy is introduced: including morphological, developmental, energetic, segmented, process-oriented and archetypal frameworks.

(<http://www.naropa.edu/academics/graduate/psychology/somatic/courses.cfm>)

Another program offers a movement observation and assessment course explaining that:

This course introduces students to movement observation and analysis within the framework of Laban Movement Analysis. In experiential and didactic frameworks, students will examine personal, relational, cultural, and societal dynamics as manifested in movement behavior. Therapeutic implications for both individuals and groups will be discussed.

(<https://duapp1.drexel.edu/webcourses/CourseListing.asp?SubjCode=ARTS&Levl=GR&Univ=DREX>)

Furthermore, according to the rules and regulations of the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, the topic of appraisal is an educational requirement. In order for a person to have successfully met the requirements for licensure, they must have had 2 semesters or 3 quarter hours focused on the topic of appraisal. (The Pennsylvania Bulletin)

It is important to gain an idea of what is currently occurring within the field of DMT, in terms of assessment, in order to gain a state of the field perspective. The practice of DMT requires research regarding assessment procedures in order to

understand what is most successful for specific populations of patients, as well as the field of DMT overall.

CHAPTER 3: METHODOLOGY

3.1 Design

The design of this study consisted of a web-based survey of dance/movement therapists regarding the assessment of their patients. This study aimed to gather information throughout the field of dance/movement therapy (DMT) regarding clinicians' use of assessment tools and procedures. The researcher designed a survey (Appendix D) that inquired about dance/movement therapists' use of assessment procedures in their clinical work. The findings from this survey will allow individuals to see how other clinicians are using assessment methods in order to create a standard of practice. The results will also aid in advancements in training and continuing education programs, as well as the opportunity to initiate further research on this matter. It is vital to contact professionals working in the field in order to understand what methods of assessment are being used at the present time.

The initial section of the survey inquires about the dance/movement therapist's background information including the institution where he or she studied, credentials, and the length of time he or she has been practicing DMT. The second section of the survey includes a clinical service description where participants are asked about the populations with whom he or she works, including the age of the population and the main diagnoses present. The third section of the survey inquires about the participant's current clinical work, including the length of time he or she has been working at their clinical setting, as well as a list of the three most common diagnoses in this setting. The final section asks participants about their specific clinical DMT assessment process. Questions were asked

regarding whether patients are assessed, what aspects of assessment are most important to consider, when an assessment occurs, and whether formal or informal procedures are used. If participants use informal methods, they were asked to explain and describe the procedure. Participants were then asked to choose aspects of movement that are important when doing an assessment and whether published DMT assessment tools are performed in their entirety. There was then an option to add any additional comments that are integral to their individual assessment process.

3.2 Subjects

All eligible respondents were professional members of the ADTA. This is signified by the holding of either of the following two credentials: Dance Therapy Registered (DTR) or American Dance Therapy Registered (ADTR). Respondents were also eligible only if they currently worked in a clinical setting. The entire pool of potential respondents that were contacted to participate in this survey was 1,025, and includes members of the American Dance Therapy Association (ADTA) who were listed on the Member's Directory page of the ADTA website. However, an individual had to have one of the aforementioned credentials in order to participate in the survey. The reasoning for this was that the researcher aimed to get an idea of how assessment is being used in the present, which required dance/movement therapists to respond who were currently working in a clinical capacity. There were no restrictions regarding the age, gender, and racial/ethnic identity of the participants. It was estimated that there could be up to 700 responses to the survey, since this is the estimated number of practicing dance/movement therapists.

Respondents to this study were recruited through direct mail or through a posting on the American Dance Therapy Association (ADTA) list serve. All members of the ADTA have access to the Member's Directory, a listing of all registered dance/movement therapists. As a student member of the ADTA, the student researcher had access to this membership directory. After approval of the study protocol by the Drexel University Internal Review Board, the student researcher posted an invitational letter (Appendix B) inviting dance/movement therapist to take the survey. An invitational letter was also sent to the entire population of ADTA professional members through direct mail. (Appendix A) According to this IRB, the researcher should have as little direct contact with respondents as possible. Invitational letters were thus mailed directly to respondents, as opposed to emailed, because this ensured that the anonymity of respondents would be maintained. Therefore, the researcher could not be contacted directly. The return address was the academic institution.

The invitational letter explained the nature of the study and invited respondents to visit the Survey Monkey webpage and fill out the survey. The URL (http://www.surveymonkey.com/s.aspx?sm=K3TaAXCUd9R2YluSPL0VtA_3d_3d) on the invitational letter allowed participants to find the survey online. Those who choose to participate in the survey did so by going to the website and filling out the survey. A follow-up reminder email was sent to participants through the ADTA list serve on March 6, 2008. (Appendix C)

There were no referral fees or incentives for participating in this survey. There was no procedure by which individual dance/movement therapists were selected or solicited for this survey. All professional therapists were contacted through the

invitational letter or the list serve posting. The potential respondent then had the option to respond. There was no paper version of this survey; therefore, in order to fill it out, participants had to visit the website and do so electronically. The Survey Monkey program ensured the anonymity of the responders through a setting within the program that allowed the researcher to block identifying information. (Appendix E)

Those who were included in this survey are professional dance/movement therapists who hold either a current DTR or ADTR credential and who are currently working with patients in a clinical setting. This may include any type of clinical work where there is treatment of patients or clients using the medium of DMT for treatment. Criteria that excluded respondents from participating in this study included dance/movement therapists who are currently not working with patients in a clinical setting, or individuals who are not DTR or ADTR credentialed.

3.3 Instrumentation

This survey (Appendix D) was compiled to gain a sense of whether dance/movement therapists are assessing their patients and how they are doing so. Respondents were asked to elaborate on their assessment process in terms of formal assessment tools used and/or individual assessment procedures developed and the theory on which they are based. The first section of this survey includes background information of the respondent, including whether they work in a clinical setting (item 1), the institution attended for certification in DMT (item 2), the highest earned DMT credential (item 3), and the year they began practicing DMT (item 4).

The second and third sections of the survey include questions regarding a description of respondents' clinical service. Respondents were asked the age (item 5) and clinical population (item 6) with whom they mainly work. Item 7 asks how long the therapist has been working in this clinical setting, followed by indicating the three most common diagnoses found in this population (item 8).

The fourth section asks respondents questions pertaining to their individual assessment procedure. Item 9 asks whether the respondent takes part in assessing their patients. If they answered no for this question, they are then asked to explain why they do not. Item 10 asks to choose the reason for assessing, which is followed by choosing what point in the therapy process they assess (item 11). Within this question, they are then asked to explain their rationale. The respondent is then asked if they use mostly formal or informal methods of assessment (item 12), and if so what formal methods are used (item 13). Item 14 is an open-ended question asking the respondent to explain informal methods that are used, only if this applies to their assessment process. The following question asks the respondent what aspects of movement are mainly focused on during an assessment (item 15). They are then asked to explain how these are used. The respondent is asked to choose any published DMT assessment tools that they may employ (item 16). Item 17 asks if the respondent uses any individually-developed assessment methods and is then asked to explain this in an open-ended format (item 18). The following question then asks them to explain how this individually-developed tool is used (item 19). Finally, item 20 is an open-ended question inviting the respondents to share any other information that is important in describing the overall assessment process.

3.4 Procedures

In order to test the effectiveness of the survey prior to its release, the student researcher asked classmates to fill out the survey as if they were credentialed dance/movement therapists. They were asked to base responses on work that they are currently doing in their clinical internships as well as on procedures used by supervisors in these settings. They were then able to offer input regarding ways to improve survey questions. Five of the survey questions were revised based on this feedback.

3.5 Data Collection

The method of data collection used in this study was a survey. All survey responses were gathered through the Survey Monkey system (www.surveymonkey.com), where the survey was created. The invitational letters for the survey were mailed out on February 10, 2008, and the survey was closed on March 16, 2008. Therefore, respondents had 35 days to respond to the survey. There was no consent form used in this study since respondents had the option to complete the survey. By completing the survey, the respondents were consenting to take part in the study. As each participant completed the survey, their responses were automatically stored in the system and were later retrieved and transferred into a database for analysis.

3.6 Data Analysis

Both quantitative and qualitative data were drawn from the responses. Descriptive statistics were formulated for each category of questions. All quantitative data were downloaded from the Survey Monkey program and imported into Statistical

Package for the Social Sciences (SPSS) where statistical analyses were conducted. These included background information, clinical service description, current clinical work, and clinical DMT assessment, found within the survey.

Frequencies and descriptive statistics were computed for the demographic and quantitated response items. The descriptive statistics, along with an initial visual inspection of the entire quantitative data set, suggested to this researcher which variables would be most fruitful for in subsequent analyses. Cross-tabs and correlational tests were then run to determine relationships among various items and features of the respondents, clinical populations and assessment procedures.

Qualitative findings were measured through open coding and content analysis of responses to search for similarities and differences in order to categorize findings. According to Patton, content analysis is “the process of identifying, coding, and categorizing the primary patterns of the data.” (1990, pp. 381) In order to find patterns within the qualitative data, the researcher then pasted the qualitative responses into a separate Microsoft Word file for each survey item. Patton (1990) explains that labeling the various kinds of data and establishing a data index is the next step in content analysis. Following Patton, the researcher then went through each survey item and labeled answers that were repeated throughout the list of responses to look for trends. Trends that appeared were then clustered and reported in text form, staying true to wording used by respondents.

3.7 Operational Definitions and Variables

1. Appraisal— the act of estimating or judging the nature or value of something or someone (www.dictionary.com)
2. Assessment—the part of the therapy process concerned with understanding a client, his condition, and therapeutic needs and remains an ongoing process throughout therapy (Bruscia, 1988)
3. Evaluation—documentation of whether or not a client's original status changed as a result of an intervention (Bruscia, 1988)
4. Treatment—interventions that are implemented that are aimed at inducing a change (Bruscia, 1988)
5. Formal Assessment—defined by the researcher as containing aspects of published assessment tools or is individually-developed but used consistently
6. Informal Assessment—defined by the researcher as assessment that is inconsistent and depends on the situation
7. Evidence-Based Practice—integrates all scientific evidence and clinical information that is used to guide and improve psychotherapy processes, interventions, therapeutic relationships, and outcomes (Goodheart & Kazdin, 2006)
8. ADTR—American Dance Therapy Registered, the credential that recognizes the attainment of the advanced level of dance/movement therapy practice and the individual's preparedness to provide supervision and training in dance/movement therapy and engage in private practice (www.adta.org)

9. DTR—Dance Therapy Registered, the entry-level credential that recognizes that the individual has a Masters Degree and is fully qualified to work in a professional treatment system (www.adta.org)

CHAPTER 4: RESULTS

4.1 Overview

The results of this study are presented according to an explanation of survey responses, demographic information of respondents, qualitative findings, and major findings. The explanation of survey responses section includes information regarding how the researcher acquired survey responses. This is followed by demographic information reported in survey responses: the background information of respondents, a description of respondents' clinical service, respondents' current clinical work, and aspects of respondents' clinical DMT assessment process. The section on qualitative findings lists qualitative responses that were offered by respondents for survey items that gave the option to explain one's rationale. Finally, the last section includes major findings, more specifically, results from statistical tests showing relationships among survey variables.

4.2 Explanation of Survey Responses

Those who responded to this survey were contacted by the researcher through the American Dance Therapy Association (ADTA) Member's Directory. Anyone can sign up to be a member of the ADTA directory, therefore the researcher was unable to distinguish between those who were credentialed dance/movement therapists and those who were not, since only credentialed dance/movement therapists could respond to the survey. Members may also include students who have not yet acquired the DMT credential awarded upon graduation from an accredited program. Therefore, an invitational letter (Appendix A) was mailed to all persons listed under the Member's

Directory, which is currently 1,025 people. Of the letters that were mailed, 34 were sent back to the researcher cited as undeliverable addresses. The same invitational letter was also emailed to 53 listed members who reside outside of the United States. Out of these emailed letters, 14 messages failed to be delivered due to insufficient email address.

There are approximately 600 to 700 credentialed dance/movement therapists throughout the world. Assuming that the majority of these professionals were contacted either through the Member's Directory or the ADTA list serve, it would be accurate to presume that the target population had the opportunity to participate in the survey. Out of this population, 62 participants responded to the survey, creating an approximate 6% response rate. Eleven of the respondents explained that they were not currently working in a clinical setting, which was one of the criteria for completing the survey. However, these respondents went on to complete the survey stating that responses were based on previous work. Their responses were included in the collected data.

4.3 Demographic Information

4.3.1 Background Information of Respondents

The following results explain information gathered from respondents regarding their background information pertinent to becoming a dance/movement therapist. Item 1 of the survey asked respondents whether they currently work in a clinical setting (Figure 1). Sixty respondents answered this question ($n=60$). Results found that 49 people (81.7%) currently work in a clinical setting, while the 11 people (18.3%) who do not currently work in a clinical setting stated that survey responses were based on previous work.

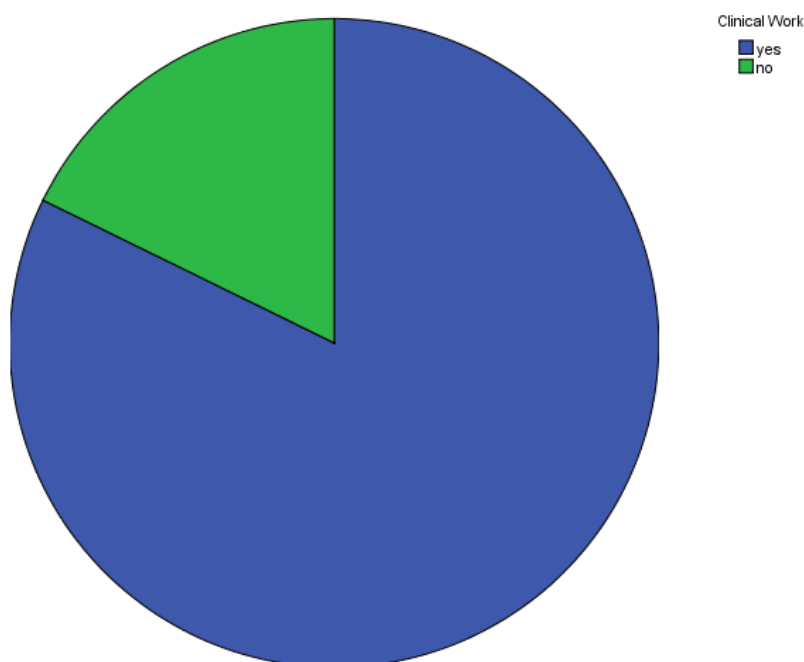


Figure 1

Item 1: Respondents work in a clinical setting

Item 2 asked respondents about the courses and educational programs completed when attaining their DMT credential (Figure 2). Sixty-two respondents answered this question ($n=62$). The majority of people, sixteen respondents (25.8%), identified graduating from Drexel University, while 12 respondents (19.4%) identified that they attended an institution other than the ones listed by the researcher. One person (1.6%) identified attending New York University and Naropa University.

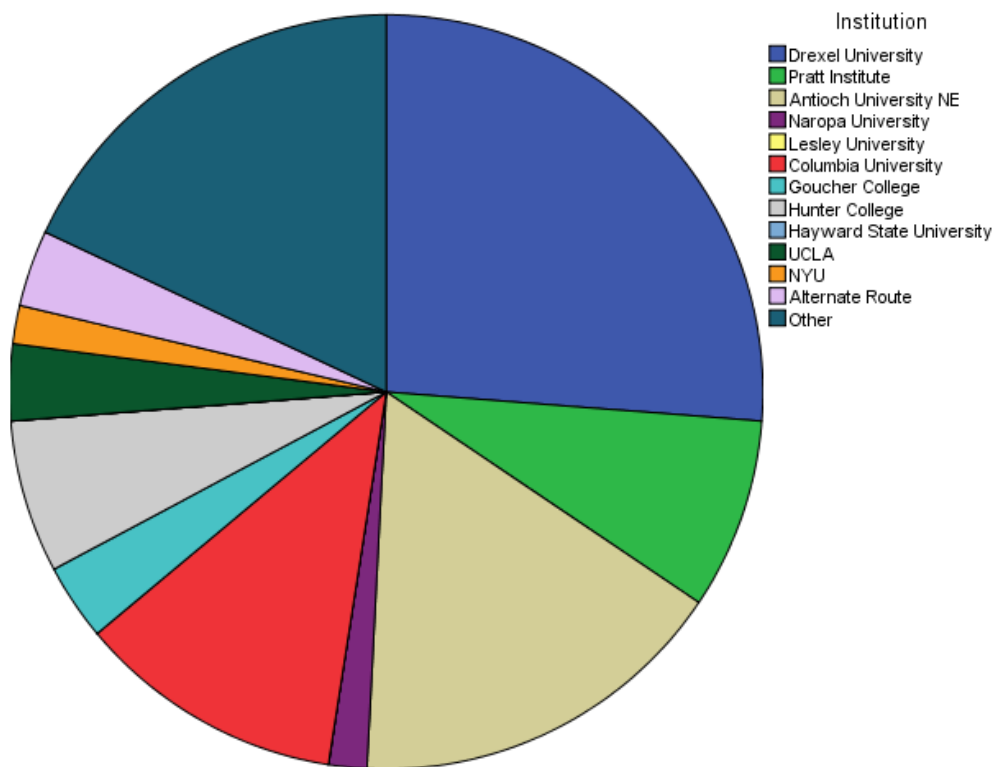


Figure 2

Item 2: Institution where respondents completed their master's in DMT

Item 3 queried respondents regarding their highest DMT credential (Figure 3).

Fifty-five respondents answered this question ($n=55$). These include either ADTR, with 32 respondents (58.2%), or DTR, with 23 respondents (41.8%).

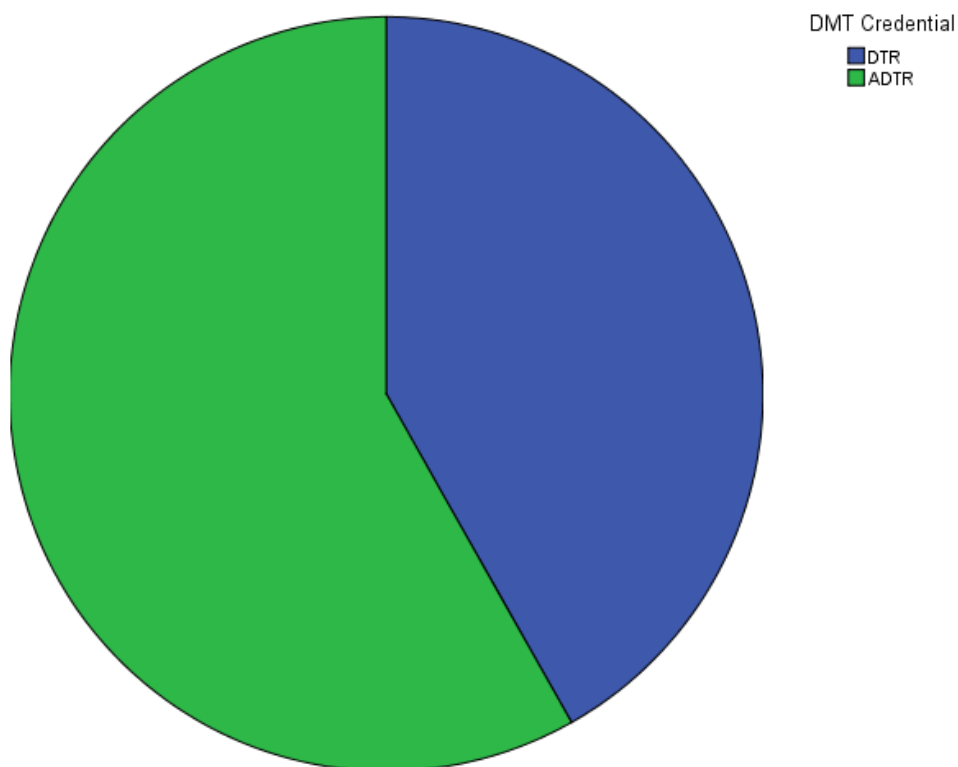


Figure 3

Item 3: Highest DMT credential for respondents

Item 4 of the survey asked respondents how long they have been practicing DMT (Figure 4). Sixty respondents answered this question ($n=60$). Twenty-six respondents (43.3%) chose the time period of 1996-2005 as their date for beginning. Eleven respondents (18.3%) chose the time periods of 1986-1995 and 2006-2007. Eight respondents (13.3%) identified starting practicing between the years of 1976 and 1985. Finally, two respondents (3.3%) identified beginning before 1966 and two respondents (3.3%) also identified starting practicing between the years of 1967 and 1975.

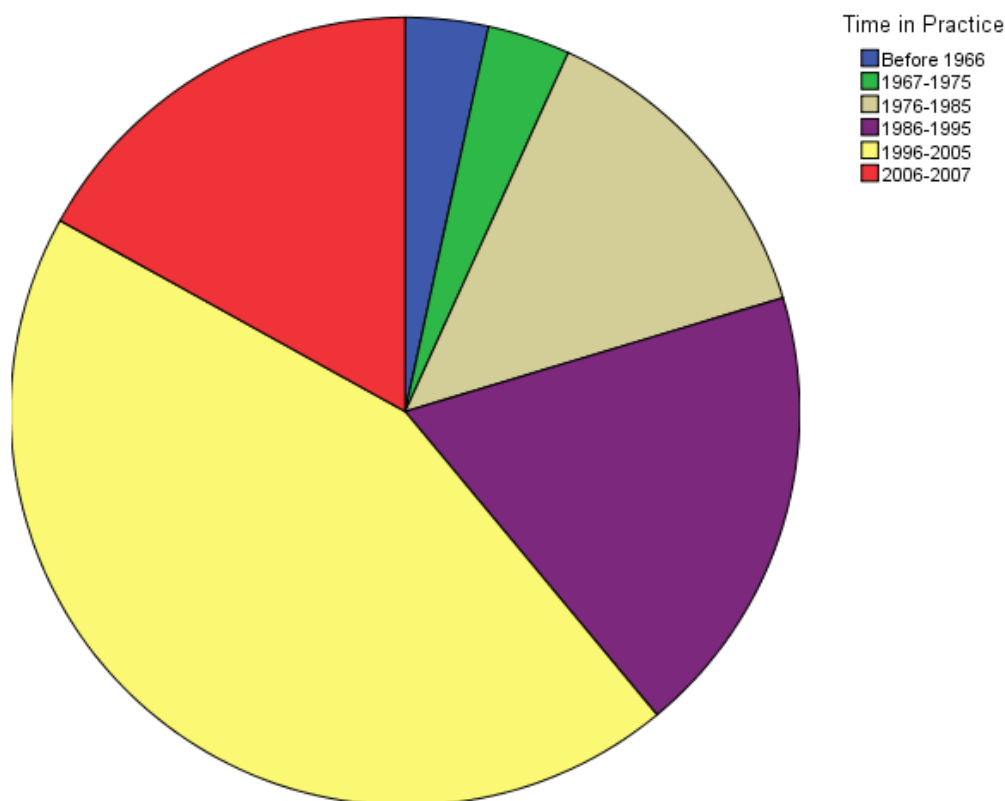


Figure 4

Item 4: The year respondents began practicing DMT

4.3.2 Description of Respondents Clinical Service

The following results provide information regarding work that the respondents are currently offering through clinical service. Item 5 of the survey asked respondents what age population they currently work with in their clinical setting. Respondents were able to choose more than one answer, depending on their clinical work and so percentages total more than 100%. Sixty-one respondents answered this question ($n=61$). Forty-seven (77.0%) identified working with the adult population. Twenty-nine respondents (47.5%) reported working with children. Twenty-five respondents (41.0%) identified

working with the adolescent population and 20 respondents (32.8%) said they work with the geriatric population.

Item 6 queried respondents regarding the clinical population with whom they mainly work (Figure 6). Sixty respondents answered this question ($n=60$). The majority of people, 13 respondents (21.7%), identified working with a population other than the ones listed. Eight respondents (13.3%) selected Autism as the most common population. Attention deficit and disruptive behaviors was selected by 2 respondents (3.3%), while one person (1.7%) identified anxiety disorder as the main population.

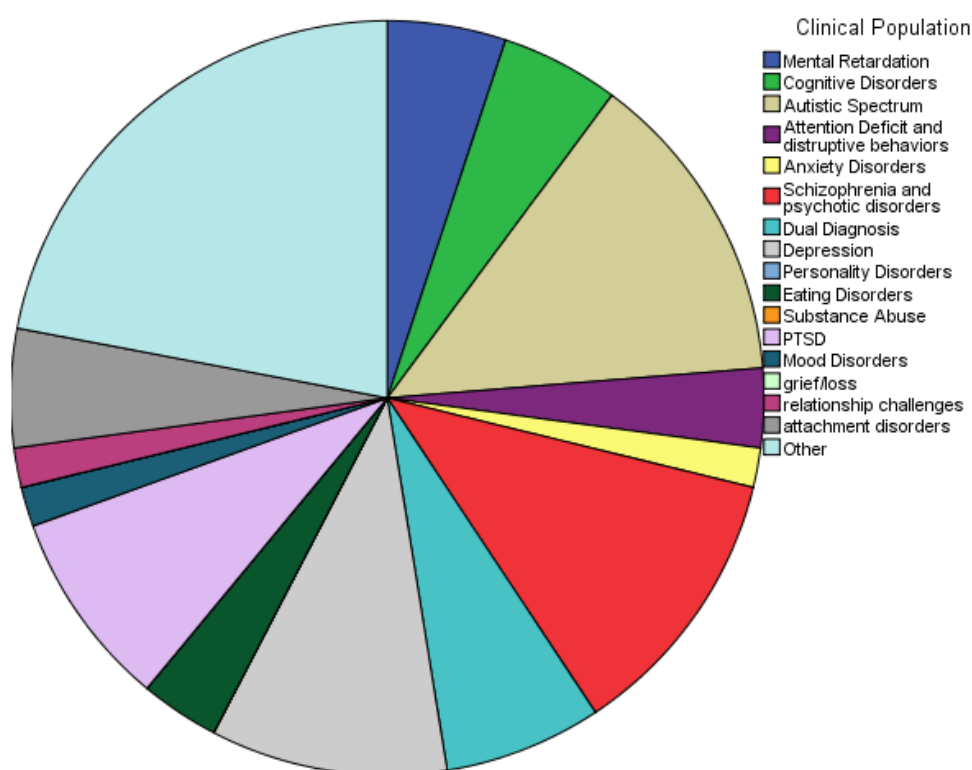


Figure 5

Item 6: The main clinical population focused on in respondents' clinical setting

4.3.3 Current Clinical Work

Respondents were then asked about the work they do in their current clinical setting. Item 7 of the survey asked respondents how long they have been working in their current clinical setting (Figure 7). Fifty-six respondents answered this question ($n=56$). The majority of people, eighteen respondents (32.1%), chose working at their clinical setting for over 10 years. Fifteen respondents (26.8%) chose 2-4 years as the length of time working in their clinical setting. Three respondents (3.4%) reported working at their current setting for less than 6 months, while one respondent (1.8 %) chose working there for 6-10 years.

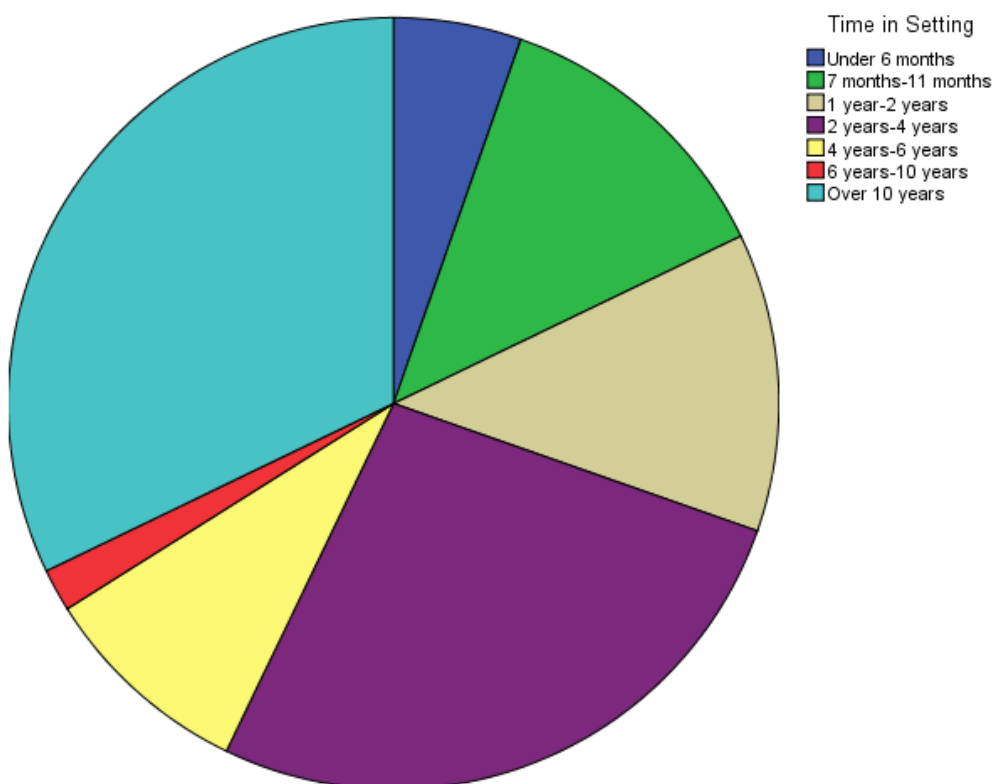


Figure 6

Item 7: Length of time respondents have worked in their clinical setting

Item 8 of the survey asked respondents to list the three main diagnoses that they work with in their clinical setting (Figure 8.1). Fifty-five respondents listed a first diagnosis ($n=55$). The majority of people, eleven respondents (20.0%), listed depression as the main diagnosis in their clinical setting. Nine respondents (16.4%) listed schizophrenia and other psychotic disorders, while 8 respondents (14.5%) listed autistic spectrum disorder as the main diagnosis. No respondents (0.0%) listed personality disorders or reactive attachment disorder as the main diagnosis. disorders or reactive attachment disorder as the main diagnosis.

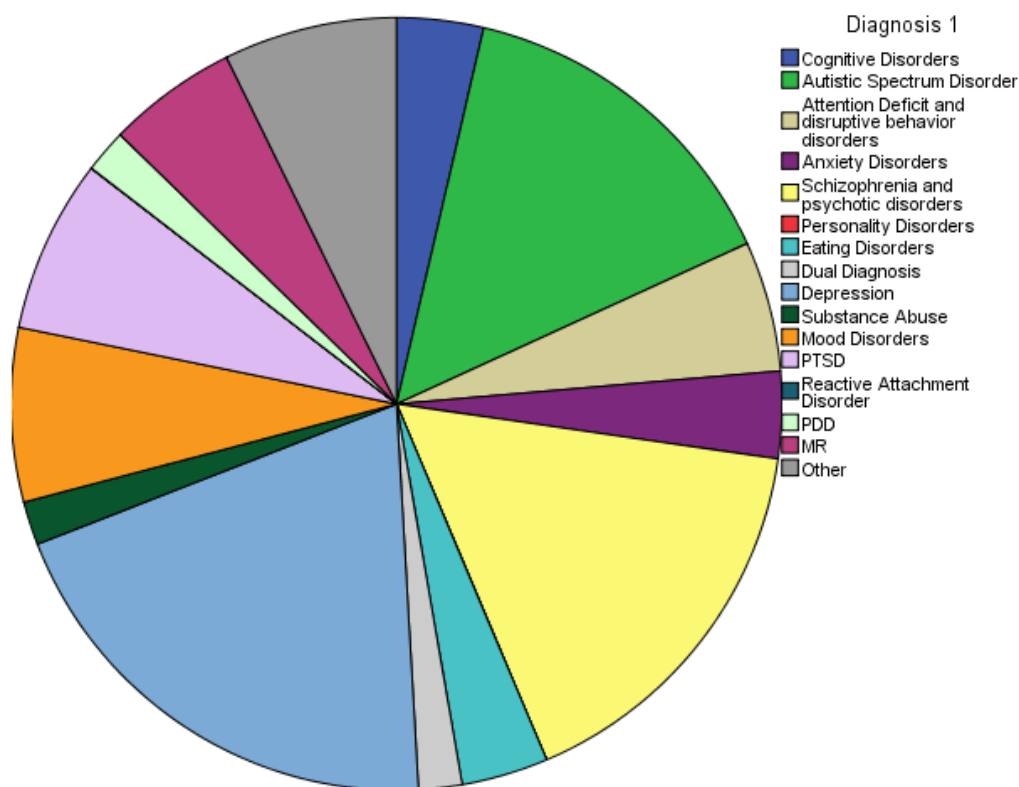


Figure 7.1

Survey Item 8: Most common diagnosis in clinical setting

Respondents then chose a second common population found at their clinical site (Figure 8.2). Fifty-three respondents listed a second diagnosis ($n=53$). The majority of respondents, 7 respondents (13.2%), listed mood disorders as a common diagnosis. Six respondents (11.3%) listed anxiety disorders and personality disorders as common diagnoses. One respondent (1.9%) listed cognitive disorders, eating disorders, reactive attachment disorder, and mental retardation as common diagnoses.

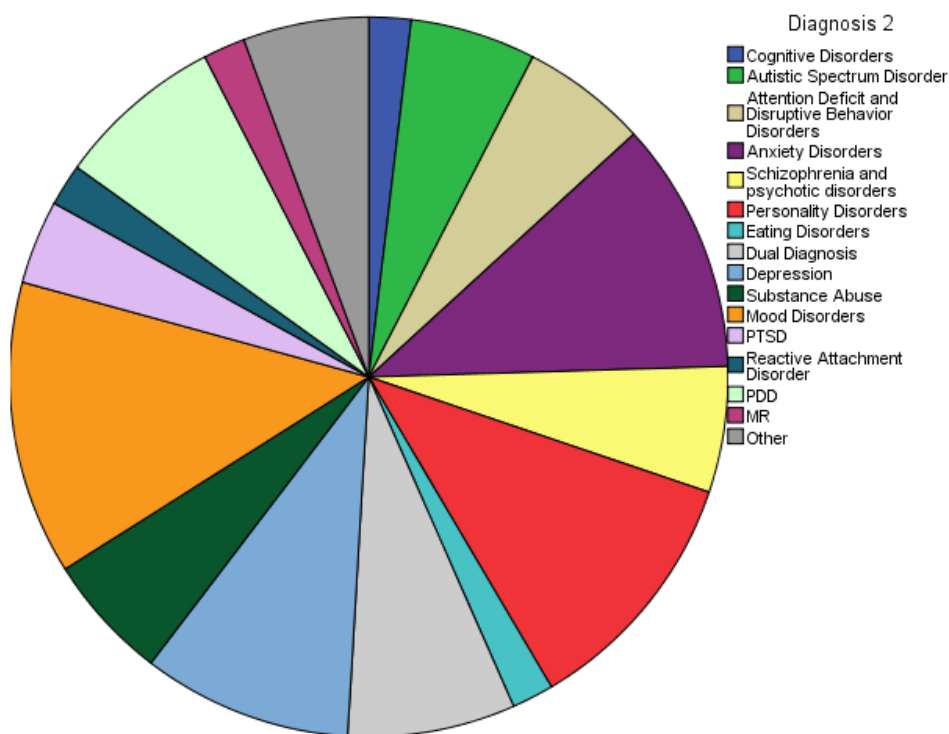


Figure 7.2

Respondents were then asked to list a third common diagnosis found at their clinical setting (Figure 8.3). Forty-six respondents identified a third diagnosis worked with in their clinical setting ($n=46$). Seven respondents (15.2%) listed mood disorders and anxiety disorders as common diagnoses. One respondent (2.2%) listed dual diagnosis and no respondents (0.0%) listed eating disorders as common diagnoses.

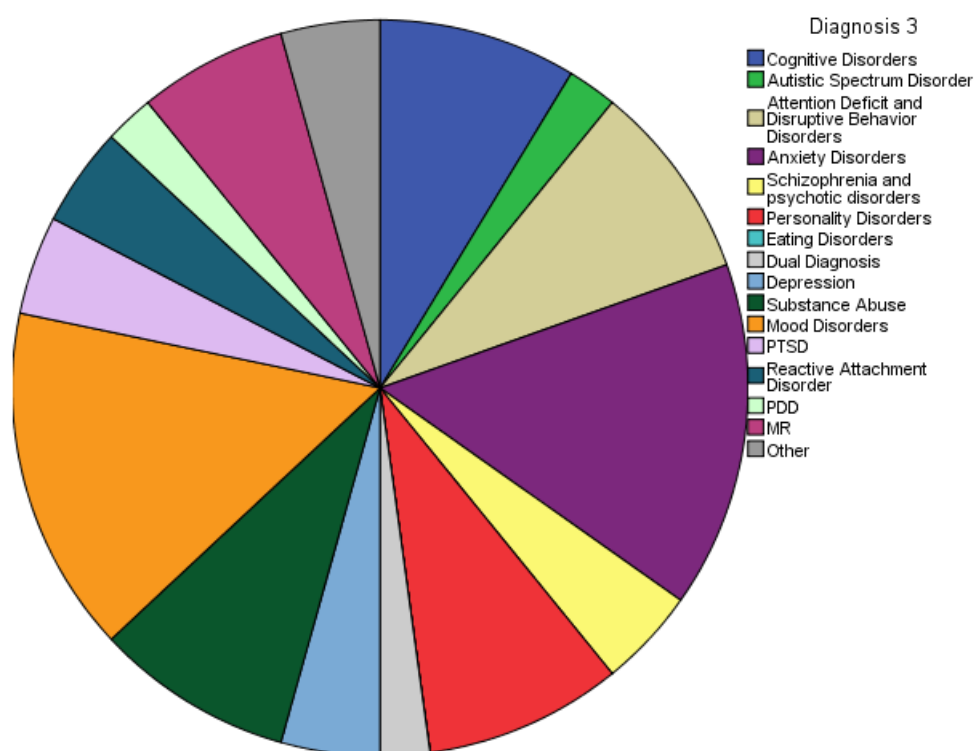


Figure 7.3

4.3.4 Clinical DMT Assessment

Item 9 inquired whether respondents perform clinical assessments of patients at their settings (Figure 9). Thirty-nine respondents answered this question ($n=39$). Thirty-

two (82.1%) identified that they do perform assessments of patients and seven (17.9%) reported that they do not perform assessments.

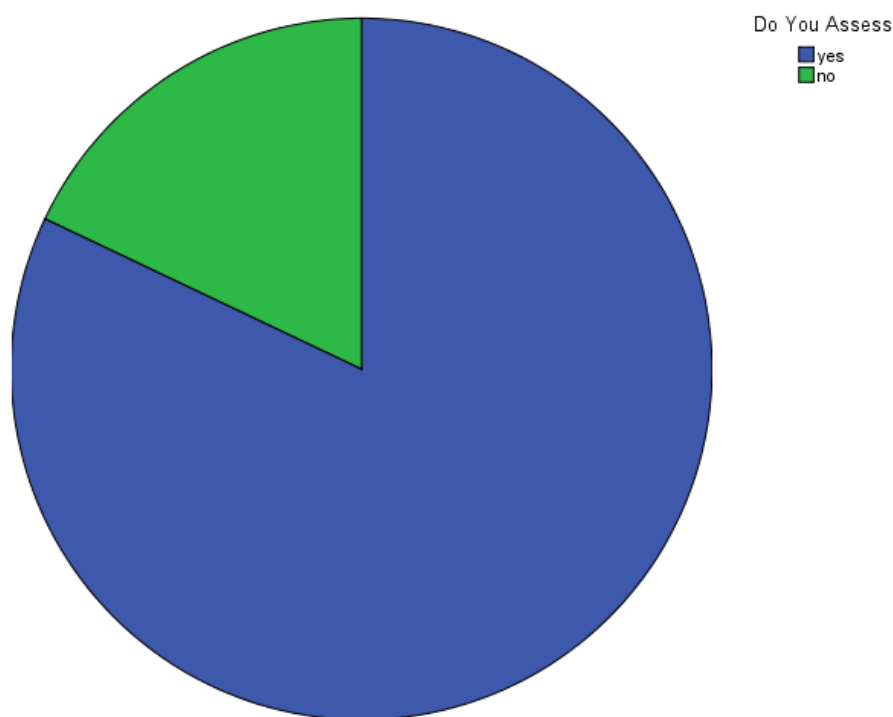


Figure 8

Item 9: Whether respondents perform clinical assessments

Item 10 of the survey asked respondents what aspects were most important to consider when assessing patients. Respondents were able to choose more than one survey option. Thirty-nine respondents answered this question ($n=39$). Twenty-three respondents (59.0%) said that keeping track of patient's progress is the most important. Twenty-two respondents (56.4%) said that treatment planning was the most important. Eighteen respondents (46.2%) chose maintaining personal awareness of the therapeutic

process as an important component. Eight respondents (20.5%) explained that it was important to consider specific documentation required by the facility in performing assessment. Finally, 8 respondents (20.5%) also said that recommendation for members of a treatment team was an important component to assessing.

Item 11 of the survey inquired about what point in the therapy process the respondent performs assessments. Respondents were able to choose up to two options depending on their clinical work. Thirty-nine respondents answered this question ($n=39$). Thirty-one respondents (79.5%) said that assessment was an ongoing process, in that there is some assessment done in every session. Fifteen respondents (38.5%) said that assessment occurs in the first session. Eight respondents (20.5%) said that it was a naturalistic observation that took place before meeting the patient. Four respondents (10.3%) said that assessment occurs at set intervals. Three respondents (7.7%) said it takes place in the second or third. Finally, no respondents (0.0%) assess patients after the fourth session.

Item 12 asked respondents whether they use mostly formal or informal assessment methods in their assessment process (Figure 12). Thirty-nine respondents answered this question ($n=39$). Twenty-four respondents (61.5%) identified that they use mostly formal assessment methods, and 15 respondents (38.5%) identified using mostly informal methods of assessment.

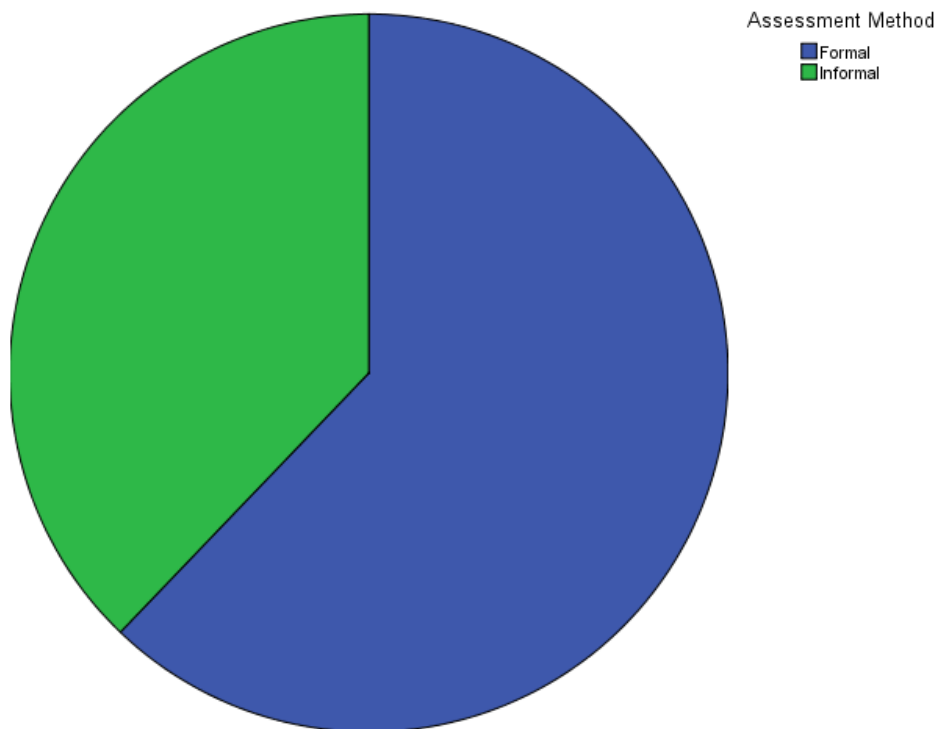


Figure 9

Item 12: Whether respondents use mostly formal or informal methods of assessment

Item 13 of the survey queried respondents regarding what formal methods of assessment they use. Respondents were able to choose more than one option for this question. Thirty-eight respondents answered this question ($n=38$). Twenty-six respondents (68.4%) identified using the effort/shape system. Fifteen respondents (39.5%) chose the Kestenberg Movement Profile (KMP). Fourteen respondents (36.8%) chose Laban Movement Analysis. Twelve respondents (31.6%) identified using formal methods other than the ones listed. No respondents (0.0%) chose the Action Profile, the Serlin Kinesthetic Imaging Profile (SKIP), or the Functional Assessment of Movement and Perception (FAMP).

Table 1

Formal Methods of Assessment										
Test	Effort/ Shape	LMA	Action Profile	SKIP	FAMP	MPI	NVAFS	KMP	Other	N/A
Raw #	26	14	0	0	0	2	1	15	12	4
Percent	68.4	36.8	0	0	0	5.3	2.6	39.5	31.6	10.5

Item 15 asked respondents what aspects of movement are mainly focused on when assessing patients. Thirty-three respondents answered this question ($n=33$). Respondents indicated that they were choosing a specific answer by explaining how it is used in their assessment process (Appendix L). Twenty-seven respondents (81.8%) chose body attitude as an aspect they focus on, whereas 23 respondents (69.7%) selected effort qualities and interaction as important to look at in assessment. Twenty respondents (60.6%) chose space as aspects that are heavily focused on. Seventeen respondents (51.5%) explained how group behavior and participation are important. Eleven respondents (33.3%) chose shape. Ten respondents (30.3%) chose developmental stage and 9 respondents (27.3%) chose diagnostic indicators as aspects that are mainly focused on. Eight respondents (24.2%) explained how they focus on pre-effort qualities in assessment. Finally, 7 respondents (21.2%) explained that they focus on something other than the options offered in the survey.

Item 17 asked respondents if they employ individually-developed assessment tools in their clinical setting (Figure 17). Thirty-six respondents answered this question ($n=36$). Nineteen respondents (52.8%) explained that they do not use individually-developed tools, while 17 respondents (47.2%) explained that they do use individually-developed assessment tools.

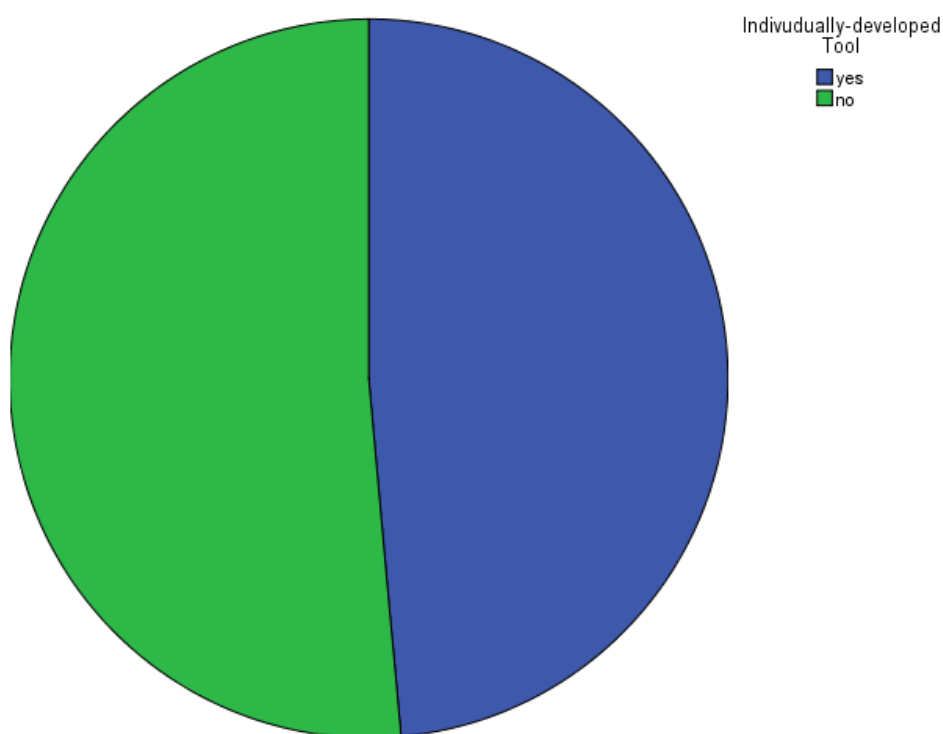


Figure 10

Item 17: Whether respondents use individually-developed assessment tools

4.4 Qualitative Findings

Item 9 of the survey asked respondents that indicated that they do not assess their patients to explain their rationale (see Appendix G). Seven respondents explained their

reasoning for not assessing ($n=7$). Four respondents indicated that it was not part of their job description for the clinical setting in which they work and two respondents explained that formal assessments were not performed; however, clients were assessed informally. Finally, one respondent explained that “groups are open to all clients”.

Item 10 of the survey offered respondents the option to explain other aspects of movement that were important to consider when assessing patients (See Appendix I). Two respondents offered additional information ($n=2$). One respondent stated using the “therapeutic process”, while another respondent explained using “Immediate Clinical Intervention”.

Item 11 of the survey gave respondents the option to explain their rationale behind choosing the time in the therapy process to assess patients (See Appendix J). Open-ended responses were collected. Thirty respondents offered additional information ($n=30$). Seventeen respondents explained process in which they assess, including assessment intervals and their rationale for using this process. Ten respondents explained that their assessment process was dictated by specific protocol for the setting in which they work. Three respondents explained that the time period for assessing depending on the population being addressed and what specific needs they tailored to.

Item 14 of the survey consisted of an open-ended question asking respondents to explain informal methods of assessment used, if any (See Appendix K). Twenty-one respondents offered information regarding informal methods ($n=21$). Nine respondents explained that they assess based on DMT theory or materials, which is specific to the population that they work with. Six respondents explained that they assess using their intuition based on what they observe, but that their intuition is grounded in theory. Four

respondents explained that they assess based on principles of the Kestenberg Movement Profile (KMP) (see literature review) and Laban Movement Analysis (LMA) (see literature review). One respondent explained using “Session notes and discussions with staff”, and another explained using the “Motivational Assessment Scale”.

Item 16 of the survey gave respondents the option to explain any other assessment tools employed in their entirety (See Appendix M). Three respondents offered open-ended information regarding this topic ($n=3$). One responded stated, “Explanation of KMP: I do not use the entire profile for the obvious reasons of time expenditure required to complete the full profile.” Another respondent explained, “I developed my own based on LMA, KMP”. Finally, another respondent stated, using “Esenak Assessment (from her book)”.

Item 18 asked respondents what components they drew from in creating their individually-developed tool. This was an open-ended question where respondents explained their thoughts (Appendix N). Seventeen respondents offered input regarding this question ($n=17$). Six respondents explained using aspects of the KMP or other developmental theory. Five respondents explained using LMA components. Five respondents explained additional theories in developing their assessment type. For example, one respondent explained, “The training given by the National Parkinson's Foundation on the complete development of PD and how it relates to the client”. Another respondent explained, “I video every assessment session and then once a year I blend my training on the BRIAAC (Behavioral Rating Instrument for Atypical and Autistic Children) with effort/shape observations”.

Item 19 asked respondents how their individually-developed assessment tool is used (See Appendix O). Respondents were given the opportunity to respond in an open-ended fashion to options provided by the researcher, including length of assessment, individual vs. group environment, whether or not there was verbal discussion with the client, and level of participation by the therapist. Fourteen respondents (77.8%) explained the length of their assessment ($n=14$). Seven respondents answered the question regarding the number of pages that the assessment consisted of. This tended to be between one and three pages. Three respondents explained the length of their assessment in terms of time, with most responses being around half an hour in length. Two other responses were collected, which include “child is given tasks” and “continued processing of mindfulness/consciousness”.

Respondents were then asked to explain their assessment procedure regarding whether it took place in an individual or group setting. Fifteen respondents (83.3%) answered this question ($n=15$). Eight respondents indicated that it took place within an individual setting only. Five respondents explained that their assessment took place in a group setting, individual setting, or both at the same time. Two respondents explained that their assessment took place within a group setting only.

Respondents were then asked to explain whether there is verbal discussion with the patient at any point throughout the assessment process. Eighteen respondents (100.0%) offered input regarding this topic ($n=18$). Ten respondents explained that there was discussion with the patient. Three respondents explained that there was no discussion with patients during the assessment process. Three respondents explained that there was sometimes discussion with patients. In addition, one respondent stated that

there was discussion but it was “kept to a minimum during observation”. Another respondent stated, “Yes. But not about doing an assessment”.

Finally, respondents were asked to comment on the level of involvement of the therapist in the assessment process. Seventeen respondents (94.4%) offered insights regarding this topic ($n=17$). Ten respondents explained that there was high therapist involvement and that the therapist was active throughout the assessment procedure. Three respondents explained that the level of therapist involvement depended on the assessment situation. Two respondents were unsure how to answer the question. One respondent indicated that there was no therapist involvement in the assessment process. Finally, one respondent also indicated that there was some therapist involvement.

Item 20 asked respondents to share any other information that is important to their assessment process (See Appendix P). Sixteen respondents offered additional information ($n=16$). Four respondents explained how assessment is critical in offering information to treatment teams. Four respondents offered encouraging words to the researcher as well as their thoughts regarding the importance of assessment in the field of DMT. One respondent explained, “Basically, the movement assessment is a tool to determine the client's movement strengths and weaknesses. Based on it, therapy can effectively strengthen and expand the client's movement repertoire, ultimately affording her/him a greater range of psychological resources.” Another respondent stated, “Assessment is done informally therapist to client. It can be done in person or on the phone. Keeping the session normal/natural is very important to the clients and care partners.” Yet another respondent explained, “In most of my work, I primarily assess using formal DSM-IV criteria for substance dependence (my main job is a substance

abuse counselor), and I use the DMT assessment as a secondary tool to help me in seeing "where the patient is at". One respondent commented that assessment is "a necessary tool in supervising", while another explained that "I use videotape for the first assessment." Finally, another respondent explained that, "I trust my own internal reactions. If my gut tells me something is 'up', I pay close attention."

4.5 Major Findings

Statistical tests were run on specific variables in order to determine relationships. A Mann-Whitney test for significance was run on the two variables of length of time respondents have been at their clinical setting and whether they assess patients. It was found that no significance relationship ($p=.581$) exists between these two variables. More specifically, it can be inferred that the length of time dance/movement therapists have worked in their clinical setting has no relationship with whether they assess patients or not (Figure 18).

Clinical Assessment related to Time in Setting	
	Time in Setting
Mann-Whitney U	97.500
Wilcoxon W	125.500
Z	-.553
Asymp. Sig. (2-tailed)	.581
Exact Sig. [2*(1-tailed Sig.)]	.603 ^a

a. Not corrected for ties.

b. Grouping Variable: Do you assess

Figure 11

A Mann-Whitney test for significance was also run on the variables of the length of time respondents have been working at their clinical site and whether they use formal or informal methods of assessment (Figure 19.1). It was found that a significant relationship ($p=.014$) exists between these two variables. The histogram indicates the direction of the relationship: the longer a respondent has been at their clinical setting, the more likely they are to use formal assessment methods (Figure 19.2). Therefore, it can be concluded that the length of time clinicians have been working in their clinical setting may influence whether they use formal or informal methods of assessment.

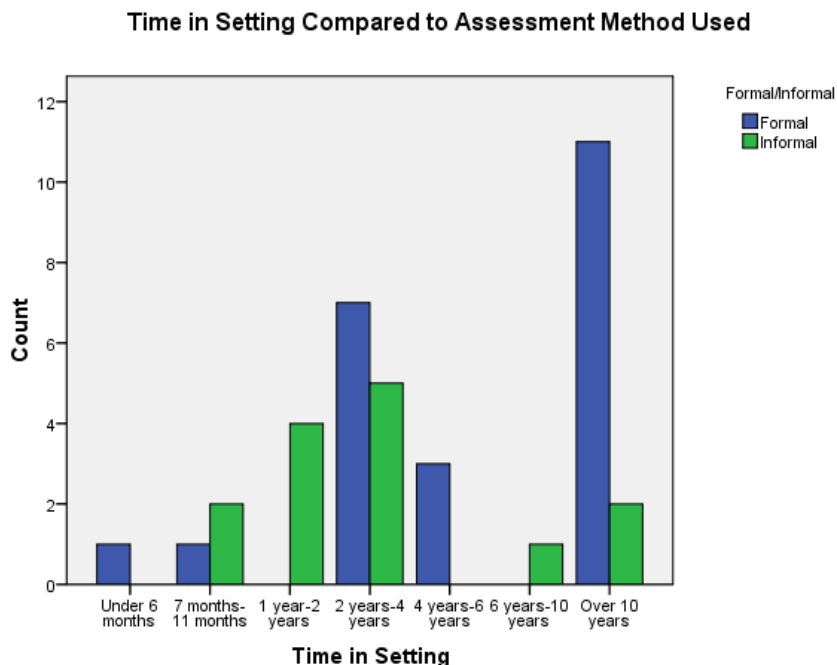


Figure 12.1

Assessment type related to Time in Setting

	Time in Setting
Mann-Whitney U	85.500
Wilcoxon W	190.500
Z	-2.464
Asymp. Sig. (2-tailed)	.014
Exact Sig. [2*(1-tailed Sig.)]	.017 ^a

a. Not corrected for ties.

b. Grouping Variable: Formal or Informal

Figure 19.2

The variables of whether respondents use formal or informal methods of assessment and whether they use individually-developed tools were then tested for significance, using the Pearson Chi-Square test for significance. A significant relationship ($p=.009$) was determined between these two variables. It can therefore be concluded that there is a positive relationship between the use of formal or informal methods of assessment and the use of individually-developed tools. The histogram shows that the direction of the relationship is: those who use formal methods are more likely to use individually-developed tools for patient assessment when compared to those who use informal methods.

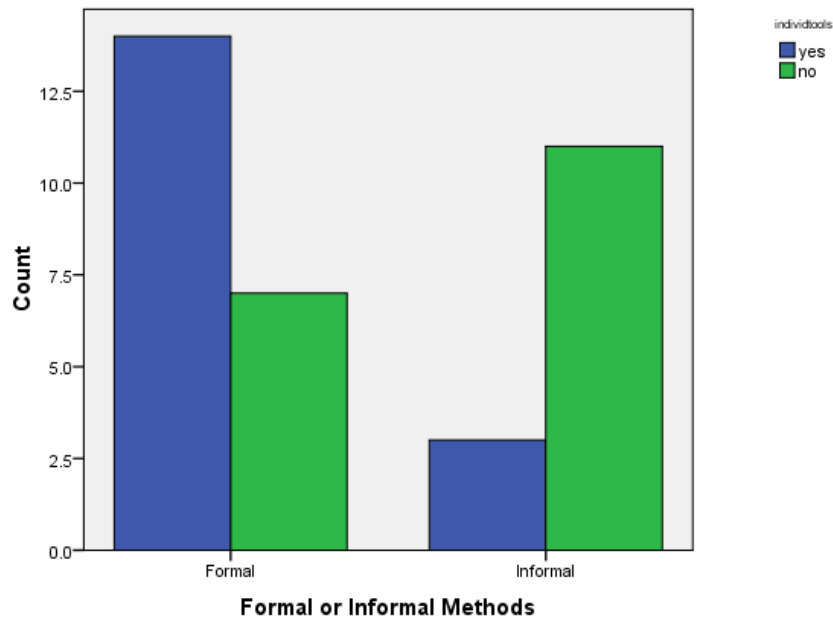


Figure 20

The variables of age population and whether a respondent uses individually-developed methods of assessment were then examined together. All four age populations were separately tested against whether a person uses individually-developed tools, using the Pearson Chi-Square test for significance. No significant relationship was found between any age population and the use of individually-developed assessment tools (Table 2). From these results, it can be inferred that working with any age population has no relationship to whether a respondent uses individually-developed assessment tools.

Table 2

Age Population Related to use of Individually-Developed Tools

Age Population	Yes	No	Percentage— Yes responses	Chi-Square	Significance Level with individually- developed tool
Child (n=29)	18	19	47.5	.219	$p=.395$
Adolescent (n=25)	10	27	41.0	.550	$p=.915$
Adult (n=47)	27	10	77.0	.353	$p=.521$
Geriatric (n=20)	11	26	32.8	.534	$p=.774$

CHAPTER 5: DISCUSSION

5.1 Overview

Assessment is an integral process in work done through dance/movement therapy. It is through the assessment that clinicians can create a baseline from which a course of treatment can be determined. Because this is such an important step in the therapeutic process, attention must be paid to how dance/movement therapists are performing assessments. In order for the field of DMT to be considered an evidence-based practice, it is important for dance/movement therapists to understand the need for standardized methods of assessing patients.

The purpose of this study was to create a state of the field summary of how dance/movement therapists are assessing patients. This chapter begins with a clinical applications section, where the researcher will explain the need for formal assessment according to the findings of the study. This section will also include applications for DMT, which will explain how the results of this study can be applied to the field of DMT in a productive manner. The following section will cover the limitations of this study, including aspects that may have deterred the researcher from obtaining optimal results. Finally, the implications for future research section will address how this study may lead to future research on the subject of assessment.

5.2 Clinical Applications

5.2.1 Need for Formal Assessment

Because dance/movement therapists are observing movement, there is much room for error when dealing with translating movement into language (Fisher, Chaiklin & Lohn, 1993) as well as having certain theoretical preferences that may bias what a clinician sees in the movement. (Goodill & Leatherbee, 1984) This creates a great need for systematic assessment methods. Results obtained through this study suggest that 38.5% of dance/movement therapists are using informal assessment methods to assess patients. Informal assessment was defined by the researcher as assessment that is inconsistent and depends on the situation. On the other hand, formal assessment was defined as containing aspects of published assessment tools or is individually-developed but used consistently. Therefore, much of the assessing that is taking place is not consistent.

The field of DMT is heavily grounded in a therapist's use of intuition based on what is seen in movement. Since systematic forms of assessment had not yet been created as the field was developing, clinicians were forced to use their intuition. (Cruz, 2006) As time passed, more systematic tools were developed for observing movement, however, informal assessment methods, such as intuition and instinct, will always be a part of work done in DMT. Nevertheless, it is apparent through the results of this study that there needs to be a clear distinction between formal and informal assessment methods.

The results of this survey suggest that there is a discrepancy between the number of respondents that said that they use formal assessment and then what they reported

using in the qualitative responses for informal aspects of assessment. In item 13 of the survey, the respondent was asked to explain what formal methods of assessment they use. Options for answering included Laban Movement Analysis (LMA) and the Kestenberg Movement Profile (KMP). Item 14 of the survey asked respondents to explain what informal methods they use in their assessment process. In their explanation, 4 respondents included either LMA or KMP as informal methods of assessing patients. In addition, 2 more respondents listed other assessment tools that were not listed in item 13 as informal methods of assessment.

The need for evidence-based practice is something that has been recognized throughout the field of mental health. With this growing trend, the field of DMT must follow suit in order to acquire the funding and respect that goes along with more evidence-based practices. (Huppert, Fabbro & Barlow, 2006) Formal assessment needs to take place in order for assessment to become systematic, reliable, and trust-worthy. This in turn will aid the field of DMT in becoming more evidence-based. According to the results from this study, only 12 out of the 62 respondents are using published assessment tools. Furthermore, among these responses some dance/movement therapists indicate that they only apply aspects of the assessments in their clinical practices. One respondent stated, “Explanation of KMP: I do not use the entire profile for the obvious reasons of time expenditure required to complete the full profile.” Yet another respondent explained, “I developed my own based on LMA, KMP”. Examples such as these provide evidence that clinicians are not implementing assessment tools that are consistent in the way that they are administered, and are therefore not systematic. Without systematic assessment processes, findings cannot be deemed reliable.

This study found a significant relationship between the length of time respondents have worked in their clinical setting and whether they use formal or informal methods of assessment (Figure 19). More specifically, the relationship explained that the longer a respondent has been at a clinical setting, the more likely he or she was to use formal assessment methods. This denotes that respondents who have worked at their clinical setting for over 10 years are the most likely to use formal assessment methods. This may have to do with the increased experience that comes with an extended amount of time working as a clinician.

5.2.2 Applications for DMT

The results of this study suggest that there is an inconsistency in the ways in which different respondents are assessing patients. From this, it appears that assessment practices in the field of DMT are not meeting certain standards set by other mental health professions. (Kazdin, 2006) To ameliorate this problem, certain steps could be taken to disseminate and systematize dance/movement therapists' assessment practices that are in keeping with the generally accepted standards of the mental health profession. As reported in Chapter 2, Bruscia (1988) explains that any assessment should have clearly defined objectives, the presence of a qualified therapist, uniqueness of clinical advantages, effective methods of data collection, reliable data, adherence to ethical standards, and the ability to lead to valid conclusions. Because all clinical populations require individualized methods of assessment, there needs to be a clear set of guidelines addressing what needs to take place in an assessment session, irregardless of the clinical

population being served. This would ensure that whatever form of assessment is used, it is systematic and used consistently.

There are implications for DMT education that could more heavily focus on assessment. Students could receive a more in depth education regarding what assessment is and existing assessment tools that can be utilized depending on the population and the information needed regarding how patients are progressing toward their goals. This can also be accomplished through continuing education. Practicing dance/movement therapists should be required to have some continuing education on assessment in order to stay abreast of new assessment tools. It is also imperative that they are reminded of the nature and importance of the assessment process.

A future study should work on creating a field standard for assessment in order to develop standards of practice with regards to the assessment process. Due to the paucity of detail within the ADTA Code of Ethics and Standards of Practice documents regarding assessment, there is little guidance for practitioners as to what assessment should entail throughout the field. (ADTA, n.d.) Through the development of a more structured assessment process, clinicians can begin to administer assessments that are following a standard guideline that is unified for all assessment procedures. By doing so, the field of DMT will work toward creating a systematic assessment process.

According to item 18 of the survey, respondents explained what components they drew from in developing their individually-developed assessment tool. Many of the respondents explained using aspects of theory or research not related to DMT. Future research could consist of a follow up interview pertaining to why respondents used non-DMT assessment tools instead of DMT-related ones in creating their assessment tool.

This will help to shed light on what may be missing within DMT assessment process that forces dance/movement therapists to rely on assessment tools of other professions.

5.3 Limitations

There were several limitations to this study that will be discussed. Most of the limitations of this study had a negative affect on the number of responses, creating a small sample size. This in turn, creates poor external validity for study findings. One of the major limitations to this study was that the invitational letter for potential respondents to take the survey was sent through direct mail. Because of the convenience of email, more responses could have potentially been collected if the invitational letter was emailed to individual members of the DMT community. Here, respondents could have simply clicked on the link to the Survey Monkey webpage and taken the survey while already at their computer.

Other limitations included technical difficulties that respondents encountered trying to access the survey or while completing it. These limitations contributed to the small sample size as well. The researcher received seven emails throughout the course of the data collection process regarding difficulties accessing the survey. In addition, 22 out of the 62 survey responses were incomplete following Item 9 of the survey. This leads the researcher to believe that there was some technical problem at this point in the survey that caused the respondents to be unable to complete survey questions. This happened to be the point in the survey where questions focused on the assessment process. Therefore, the most pertinent data for these incomplete surveys was missing.

A final limitation of this study involved the listserv posting of the invitational letter on the ADTA website. The day that this email posting was sent, there was another survey posted as well. Therefore, some respondents may have chosen not to respond to both surveys. Along with the other limitations of this study, this may have contributed to the small sample size for this survey.

5.4 Implications for Future Research

The results of this state of the field survey can aid in creating an understanding of how assessment is being implemented within the field of DMT. From these results, further research can delve into specific aspects of assessment in hopes to increase the use of assessment in clinical practice. One option for further research should involve generating research to develop and test assessment methods. Because therapy is vastly different depending on the population, assessment tools need to be developed that will address the individual needs of a specific clinical population. Furthermore, studies should be done on existing assessment tools to determine and strengthen their validity and reliability. Since translating movement qualities into comprehensible data is a cumbersome task, many clinicians are apprehensive to use lengthy and time-consuming assessment tools. As a result, future research should address the need for shorter, user-friendly assessment measures that will be able to derive valid information. By accomplishing this, clinicians will be more apt to assess patients using a more consistent and valid tool.

As seen through the results of this study, 47.2% of dance/movement therapists are utilizing individually-developed assessment tools. In order to ensure that these

individualized tools are producing adequate results, guidelines should be developed for creating assessment tools so that clinicians are assessing properly through their own means. These guidelines should work to educate clinicians on the purpose of assessment and what variables must be obtained from it to provide evidence for treatment effectiveness. Because this is a young field, it is the responsibility of practicing clinicians to produce research that will work to systematize the assessment process for the field of DMT.

Because of the lack of research validating certain assessment tools, as well as the great deal of time necessary to complete many of the existing assessment instruments, the field of DMT is currently without a standardized assessment process. This author submits that without this, the growth and validity of the field are compromised and steps should be taken to address this problem as the field continues to mature.

CHAPTER 6: SUMMARY AND CONCLUSIONS

The purpose of this study was to gain a state of the field perspective of how dance/movement therapists are assessing patients within their clinical work. The problem that was addressed is the insufficient understanding of how patients are being assessed throughout the field of DMT. The ambiguity regarding the use of assessment tools creates difficulties in recognizing how the field understands patients through the assessment process. The reason it is important to address this problem is because assessment is necessary in order to create a baseline for treatment, determine how therapy should progress, to create treatment plans and determine if treatment was effective. After reviewing existing literature on assessment in DMT, the researcher found a gap regarding the need for evidence-based practices in the way that DMT research compares to that of the mental health field overall. It appeared that the lack of research regarding many aspects of assessment leaves the field of DMT at the disadvantage of not being viewed as an evidence-based practice.

Consequently, the researcher created a survey that questioned current dance/movement therapists regarding their individual assessment process. The survey addressed aspects of respondents' clinical work regarding background information, a clinical service description, and clinical DMT assessment information. The survey yielded 62 responses from dance/movement therapists throughout the world regarding their work in clinical settings.

In terms of a clinical service description, survey questions queried about the nature of respondent's clinical work with regards to the utilization of assessment methodology. Results from this section of the survey found that the majority of

respondents work with the adult population, as opposed to the child, adolescent, or geriatric populations. Most respondents reported working with autism as their main clinical population. Finally, the majority of respondents also identified having worked at their site for over 10 years.

In addressing respondents' DMT assessment process, the survey found that most of the respondents indicated that they do assess patients. Twenty-three respondents (59%) said keeping track of patient's progress was most important to consider. Thirty-one respondents (79.5%) explained that the assessment process was ongoing. Twenty-four respondents (61.5%) said they use formal over informal assessment methods. Finally, the majority of respondents indicated that they do not use individually-developed tools.

The researcher tested several variables in order to determine significant trends that would explain how assessment was used. It was found that no significance relationship exists between the variables of length of time respondents have been at their clinical setting and whether they assess patients. The variables of length of time respondents have been working at their clinical site and whether they use formal or informal methods of assessment were also tested for significance. It was found that a significant relationship exists, concluding that the longer a respondent has been at the clinical setting, the more likely he or she is to use formal assessment methods. The variables of whether respondents use formal or informal methods of assessment and whether they use individually-developed tools were tested for significance as well. A significant relationship was discovered, in that those who use formal methods are more likely to use individually-developed tools than those who use informal methods.

Through the qualitative and quantitative findings of this study, certain implications can be derived for the field of DMT. It is apparent through the results of this study that there needs to be a clear distinction between formal and informal assessment methods. With a striking number of respondents using mostly informal methods of assessment, there seems to be an unclear idea of the need for systematic assessment procedures. With the growing trend throughout the mental health field toward more evidence-based treatment, the field of DMT must adapt to this change in order to be deemed a reliable option for treatment.

It is common for clinicians to use individualized methods of assessment due to the specific needs of each population; however, all clinicians must be clear regarding what needs to take place in an assessment session, irregardless of the clinical population at hand. Guidelines should be developed for creating assessment tools so that assessments are being administered consistently and strategically. In addition, DMT education should focus more heavily on assessment, incorporating it into all course material. Mandating that assessment education be taken for continuing education credits would help to decrease this problem as well. Further research needs to be conducted to develop valid and reliable assessment methods for administration to a range of patient populations.

REFERENCES

- American Dance Therapy Association. (n.d.) Retrieved April 15th, 2008 from www.adta.org.
- Anderson, C. M. (1999). *Linking functional assessment with diagnostic classification: Development of functional assessment methodology*. Unpublished doctoral dissertation, Eberly College of Arts and Sciences, West Virginia.
- Antioch Universtiy NE course descriptions. (n.d.) Retrieved June 6th, 2008 from <http://www.antiochne.edu/ap/dmt/degreereqs.cfm#MAmtcp>.
- Antony, M. M., & Roemer, L. (2003). Behavior Therapy. In Gurman, A. S. & Messer, S. B. (Eds.) *Essential Psychotherapies: Theory and Practice (2nd Ed.)*. New York, NY: Guilford 22 Press.
- Berklein, S. B. & Sossin, M. K. (2007). Nonverbal indices of stress in parent-child dyads: Implications for individual and interpersonal affect regulation and intergeneration transmission. In S. C. Koch & S. Bender (Eds.), *Movement Analysis: The legacy of Laban, Bartenieff, Lamb & Kestenberg*. (pp. 128-141). Berlin, Germany: Logos Verlag Berlin.
- Berrol, C. F., Katz, S. S., Lombardo, N. E., & Ooi, W. L. (1996) Dance/movement therapy with older individuals who have sustained neurological insult. (AoA Grant Number: 90 AM 0669) Columbia, MD: American Dance Therapy Association.
- Bruscia, K. (1988). Standards for clinical assessment in the arts therapies. *The Arts in Psychotherapy*, 15, 5-10.

- Cassirer, E. (1969). The concept of group and the theory of perception. In P. Tibbets (Ed.), *Perception: Selected Readings in Science and Phenomenology*. New York, NY: Quadrangle.
- Columbia University course descriptions. (n.d.) Retrieved June 6th, 2008 from http://www.colum.edu/Academics/Graduate_Study/Dance_Movement_Therapy_and_Counseling/Course_Descriptions.php.
- Cowie, B. & Bell, B. (1999). A model of formative assessment in science education. *Assessment in Education: Principles, Policy & Practice*, 6, 101-117.
- Cruz, R. F. (1995). An empirical investigation of the Movement Psychodiagnostic Inventory (Doctoral dissertation, The University of Arizona). *Dissertation Abstracts International (2B)*, (UMI No.AAM962042257).
- Cruz, R. F. & Koch, S. C. (2004). Issues of validity and reliability in the use of movement observations and scales. In Cruz, R. F. & Berrol, C. F. (Eds.), *Dance/movement therapists in action: A working guide to research options*. Springfield, IL: Charles C. Thomas.
- Cruz, R. F. (2006). Assessment in dance/movement therapy. In *Creative arts therapies manual: A guide to the history, theoretical approaches, assessment, and work with special populations of art, play, dance, music, drama, and poetry therapies*, S. L. Brooke (Ed.) Springfield, IL: Charles C Thomas.
- Cruz, R. F. & Hervey, L. W. (2001). The American Dance Therapy Association research survey. *American Journal of Dance Therapy*, 23, 89-118.
- Davis, M. (1997). *Guide to movement analysis methods part 2: Movement Psychodiagnostic Inventory*. Available from the author at madavis95@aol.com.

- Davis, M., Lausberg, H., Cruz, R. F., et al. (2007) The Movement Psychodiagnostic Inventory. In S. C. Koch & S. Bender (Eds.), *Movement Analysis: The legacy of Laban, Bartenieff, Lamb & Kestenberg*. (pp. 119-129). Berlin, Germany: Logos Verlag Berlin.
- Dayanim, S., Goodill, S. W. & Lewis, C. (2006). The moving story effort assessment as a means for the movement assessment of preadolescent children. *American Journal of Dance Therapy*, 28, 87-106.
- Drexel University course descriptions. (n.d.) Retrieved June 6th, 2008 from <https://duapp1.drexel.edu/webcourses/CourseListing.asp?SubjCode=ARTS&Level=GR&Univ=DREX>.
- Dulicai, D. (1977). Nonverbal assessment of family systems: A preliminary study. *Art Psychotherapy*, 4, 55-62.
- Espenak, L. (1989). Movement diagnosis tests and the inherent laws governing their use in treatment: An aid in detecting the lifestyle. *American Journal of Dance Therapy*, 11, 77-83.
- Fischer, J., & Chaiklin, S. (1993). Meeting in movement: The work of the therapist and the client. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 136-153). Columbia, MD: The Marian Chace Memorial Foundation of the American Dance Therapy Association.
- Garrison, C. & Ehringhaus, M. (1999). *Formative and summative assessment in the classroom*. Retrieved July 6th, 2008, from National Middle School Association, Helping you Achieve Successful Schools for Young Adolescents Web site:

<http://www.nmsa.org/Publications/WebExclusive/Assessment/tabid/1120/Default.aspx>

- Goodheart, C. D., Kazdin, A. E., & Sternberg, R. J. (2006). *Evidence-Based Practice: Where Practice and Research Meet*. Washington, DC: American Psychological Association.
- Goodill, S. W. & Leatherbee, T. (1984). *A primer for assessment and evaluation in dance & movement therapy*. Philadelphia, PA: Hahnemann University.
- Hastie, S. C. (2006). The Kestenberg Movement Profile. In *Creative arts therapies manual: A guide to the history, theoretical approaches, assessment, and work with special populations of art, play, dance, music, drama, and poetry therapies*, S. L. Brooke (Ed.) Springfield, IL: Charles C Thomas.
- Haynes, S. N., Richard, D. C., & Kubany, E. S. (1995). Content validity in psychological assessment: A functional approach to concepts and methods. *Psychological Assessment*, 7, 238-247.
- Huppert, J. D., Fabbro, A., & Barlow, D. H. (2006). Evidence-based practice and psychological treatments. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet*. (pp. 131-152). Washington, DC: American Psychological Association.
- Karkou, V. & Sanderson, P. (2001). Report: Theories and assessment procedures used by dance/movement therapists in the UK. *The Arts in Psychotherapy*, 28, 197-204.
- Kazdin, A. E. (2006). Assessment and evaluation in clinical practice. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where*

practice and research meet. (pp. 153-177). Washington, DC: American Psychological Association.

Koch, S. C. (2007). Basic principles of movement analysis: Steps toward validation of the KMP. In S. C. Koch & S. Bender (Eds.), *Movement Analysis: The legacy of Laban, Bartenieff, Lamb & Kestenberg.* (pp. 119-129). Berlin, Germany: Logos Verlag Berlin.

Lesley University course descriptions. (n.d.) Retrieved June 6th, 2008 from

http://www.lesley.edu/gsass/exp_ma_dance_mental_health_spec.html.

Levy, F. J. (1988). *Dance/Movement Therapy: A Healing Art.* Reston, VA: The American Alliance for Health, Physical Education, Recreating, and Dance.

McCoubrey, C. (1987). Intersubjectivity vs. objectivity: Implications for Effort observation and training. *Movement Studies: A Journal of the Laban/Bartenieff Institute of Movement Studies*, 2, 3-6.

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative and mixed methods.* London: Sage Publications.

Naropa University course descriptions. (n.d.) Retrieved June 6th, 2008 from

<http://www.naropa.edu/academics/graduate/psychology/somatic/courses.cfm>.

North, M. (1972). *Personality assessment through movement.* Boston, MA: Plays, INC.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods (2nd Ed.).* London, England: Sage Publications.

Pratt Institute course descriptions. (n.d.) Retrieved June 6th, 2008 from

<http://www.pratt.edu/arttherapy>.

- Ruttenberg, B. A. et al. (1976). *Behavior Rating Instrument for Autistic and other Atypical Children (BRIAAC)*. Chicago, IL: Stoelting Co.
- Sandel, S. L., Chaiklin, S., & Lohn, S. (1993). *Foundations of Dance/Movement Therapy: The Life and Work of Marian Chase*. Columbia, MD: The Marion Chase Fund of the American Dance Therapy Association.
- Serlin, I. SKIP (Serlin Kinesthetic Imagery Profile For Women With Breast Cancer). Unpublished Manuscript.
- Serlin, I. A. Serlin Kinesthetic Imagery Profile (SKIP). Unpublished Manuscript.
- The Pennsylvania Bulletin. *State board of social workers, marriage and family therapist and professional counselors*. (49 PA. Code CHS. 47-49) Licensure. Pennsylvania.
- Westbrook, B. K. & Sing, M. (1988). A psychiatric movement assessment scale with developmental considerations. *The Arts in Psychotherapy*, 15, 37-46.
- Winter, D. D. (1987). Field studies of action profiling reliability. *Movement Studies: A Journal of the Laban/Bartenieff Institute of Movement Studies*, 2, 21-22.
- Winter, D. D. (1992) Body movement in cognitive style: Validation of action profiling. In S. Loman & R. Brandt (Eds.) *The Body Mind Connection in Human Movement Analysis*. Keene, NH: Antioch New England Graduate School.
- Zwerling, I. (1989). The creating arts therapies as “real therapies”. *American Journal of Dance Therapy*, 11, 19-26.

APPENDIX A: Initial Survey Invitation

Survey of Assessment in Dance/Movement Therapy Practice

Dear Colleague,

My name is Megan Powell and I am currently enrolled in the dance/movement therapy program at Drexel University. For my thesis, I have chosen to research how practicing dance/movement therapists are choosing to assess their patients. My goal is to gain a clear understanding of how assessment is used throughout the field of DMT. To facilitate this effort, I am looking for input from dance/movement therapists who currently do clinical work in the field. You have received this letter because you are listed in the ADTA Directory as having either your DTR or ADTR. I have created a web-based survey consisting of a few questions on how methods of assessment are used in your clinical setting.

Ambiguity regarding the use of assessment tools creates difficulties in recognizing how the field is sufficiently or insufficiently understanding patients. It is important to address this problem because assessment is integral to creating a baseline for treatment, determining what direction therapy should progress toward and creating a treatment plan. The problem that is being addressed through this study is the insufficient understanding of how patients are being assessed in everyday clinical practice.

Results from this study may be helpful to the field as an evidence-based discipline. Please visit this website address:
http://www.surveymonkey.com/s.aspx?sm=K3TaAXCUd9R2YluSPL0VtA_3d_3d
and take 15-20 minutes to offer some insight into your work and thoughts about assessment in dance/movement therapy. Please respond to this survey before March 10, 2008. By completing this survey, you will be indicating your willingness to participate in this survey. All of the information you share will remain anonymous and confidential. If you have any further questions or concerns regarding this survey please contact my faculty advisor. For further information on rights as a research subject please contact Drexel's Institutional Review Board (IRB) at (215) 762-3453.

I thank you in advance for your time and input.

Sincerely,
Megan Powell
Sherry Goodill PhD., ADTR,
NCC, LPC, Faculty Advisor

APPENDIX B: Initial Email Survey Invitation Listserve Posting

Survey of Assessment in Dance/Movement Therapy Practice

Dear ADTA ListServe Subscribers,

My name is Megan Powell and I am currently enrolled in the dance/movement therapy program at Drexel University. For my thesis, I have chosen to research how practicing dance/movement therapists are choosing to assess their patients. My goal is to gain a clear understanding of how assessment is used throughout the field of DMT. To facilitate this effort, I am looking for input from dance/movement therapists who currently do clinical work in the field. I have created a web-based survey consisting of a few questions on how methods of assessment are used in your clinical setting. Professional dance/movement therapists who hold an active ADTR or DTR credential are eligible to participate in the study by completing the survey.

Ambiguity regarding the use of assessment tools creates difficulties in recognizing how the field is sufficiently or insufficiently understanding patients. It is important to address this problem because assessment is integral to creating a baseline for treatment, determining what direction therapy should progress toward and creating a treatment plan. The problem that is being addressed through this study is the insufficient understanding of how patients are being assessed in everyday clinical practice.

Results from this study may be helpful to the field as an evidence-based discipline. Please visit this website address:
http://www.surveymonkey.com/s.aspx?sm=K3TaAXCUd9R2YluSPL0VtA_3d_3d
listed below and take 15-20 minutes to offer some insight into your work and thoughts about assessment in dance/movement therapy. Please respond to this survey before March 10, 2008. By completing this survey, you will be indicating your willingness to participate in this survey. All of the information you share will remain anonymous and confidential. If you have any further questions or concerns regarding this survey please contact my faculty advisor. For further information on rights as a research subject please contact Drexel's Institutional Review Board (IRB) at (215) 762-3453.

I thank you in advance for your time and input.

Sincerely,
Megan Powell
Sherry Goodill PhD., ADTR,
NCC, LPC, Faculty Advisor

APPENDIX C: Follow-Up Reminder for Survey—ListServe Posting

Dear ListServe Subscriber,

This is a reminder of the survey that I have created for my Master's Thesis at Drexel University for dance/movement therapy. To remind you, I am surveying dance/movement therapist who are either DTR or ADTR credentialed and that work in clinical settings. The survey aims to gather information on how dance/movement therapists are assessing patients/clients. For those of you who still wish to respond to this survey, your input would be extremely valuable.

For those of you who have already completed this survey I would like to thank you for your time and input.

For those of you who did not receive the initial invitation to complete this survey, I would like to invite you to visit the following link:
http://www.surveymonkey.com/s.aspx?sm=K3TaAXCUd9R2YluSPL0VtA_3d_3d and take about 15 minutes to complete this survey.

Sincerely,
Megan Powell
Sherry Goodill PhD., ADTR,
NCC, LPC, Faculty Advisor

APPENDIX D: Survey

1. Background Information

1. Do you currently work with patients in a clinical setting?

- ☐ yes
☐ no

2. At what institution did you receive your master's in Dance/Movement Therapy?

- ☐ Drexel University (formerly MCP Hahnemann University)
☐ Pratt Institute
☐ Antioch University New England
☐ Naropa University
☐ Lesley University
☐ Columbia College
☐ Goucher College
☐ Hunter College
☐ Hayward State University
☐ UCLA
☐ New York University
☐ Alternate Route
☐ Other (please specify)

3. Select your highest earned DMT credential.

- ☐ DTR
☐ ADTR

4. How long have you been practicing Dance/Movement Therapy?

- ☐ Before 1966
☐ 1966-1975
☐ 1976-1985
☐ 1986-1995
☐ 1996-2005
☐ 2006-2007

2. Clinical Service Description**5. What age population do you work with? (you may select more than one)**

- ☐ child
☐ adolescent
☐ adult
☐ geriatric

6. What clinical population are you MAINLY working with? (please select only one)

- ☐ Mental Retardation (MR)
☐ Cognitive Disorders (ex. Dementia)
☐ Autistic Spectrum
☐ Attention Deficit and Disruptive Behavior Disorders
☐ Anxiety Disorders
☐ Schizophrenia and other psychotic disorders
☐ Dual Diagnosis
☐ Depression
☐ Personality Disorders
☐ Eating Disorders
☐ Substance Abuse
☐ Post Traumatic Stress Disorder (PTSD)
☐ Mood Disorders
☐ grief/loss
☐ relationship challenges
☐ attachment disorders
☐ Other (please specify)

3. Current Clinical Work

The following questions relate only to the population that you identified as the main setting/population of your current clinical work.

7. How long have you been working in this clinical setting?

- ☐ Under 6 months
- ☐ 7 months-11 months
- ☐ 1 year-2 years
- ☐ 2 years-4 years
- ☐ 4 years-6 years
- ☐ 6 years-10 years
- ☐ Over 10 years

8. List the most common diagnoses of this population. (please select one from each list)

Diagnosis #1

Diagnosis #2

Diagnosis #3

Other (please specify)

4. Clinical DMT Assessment

The remaining questions concern how you conduct DMT assessment of these patients/clients of the population you identified in the questions above.

9. Dependent on the clinical setting where you work, do you assess your patients?

☐ yes

☐ no (please explain)

10. What aspects are MOST important for you to consider when assessing your patients? (please select up to TWO)

☐ Treatment planning

☐ Documentation that is required by the facility

☐ Maintaining personal awareness of the therapeutic process

☐ Keeping track of patient's progress

☐ Recommendations for members of treatment teams

☐ Others that apply

11. At what points in the therapy process do you assess your patients? (please choose up to TWO and briefly explain your rationale)

☐ Naturalistic Observation before meeting the patient

☐ The first session

☐ Second or third session

☐ After the fourth session

☐ At set intervals

☐ It is an ongoing process—in that there is some assessment done in every session

please elaborate

12. Do you use MOSTLY use formal or informal methods in assessing your patients?

☐ Formal--contains aspects of published assessment tools, or is individually-developed but is used consistently

☐ Informal--is inconsistent and depends on the situation

13. What formal methods do you use (if any)? (please choose as many as apply)

- ☐ Effort/Shape system
- ☐ Laban Movement Analysis (LMA)
- ☐ Action Profile
- ☐ (SKIP)
- ☐ Functional Assessment of Movement and Perception (FAMP)
- ☐ Movement Psychodiagnostic Inventory (MPI)
- ☐ Nonverbal Assessment of Family Systems (NVAFS)
- ☐ Kestenberg Movement Profile (KMP)
- ☐ Other
- ☐ I do not use formal assessment methods

14. What informal methods do you use (if any)?

15. What aspects of movement do you MAINLY focus on when assessing patients?
(Please offer a brief example of how the chosen elements are applied in your clinical setting—you may choose more than one)

Body	<input type="text"/>
Effort Qualities	<input type="text"/>
Pre-effort Qualities	<input type="text"/>
Shape	<input type="text"/>
Space	<input type="text"/>
Interaction	<input type="text"/>
Diagnostic indicators	<input type="text"/>
Developmental stages (KMP)	<input type="text"/>
Body image	<input type="text"/>
Group behavior/participation	<input type="text"/>
other	<input type="text"/>

16. Do you employ any of the published DMT-related assessment tools in their entirety? (If so, please select up to TWO from the list)

- ☐ Serlin Kinesthetic Imaging Profile (SKIP)
- ☐ Functional Assessment of Movement and Perception (FAMP)
- ☐ Kestenberg Movement Profile (KMP)
- ☐ Laban Movement Analysis (LMA)
- ☐ Movement Psychodiagnostic Inventory (MPI)
- ☐ Nonverbal Assessment of Family Systems (NVAFS)
- ☐ Other (please specify)

17. Do you use individually-developed assessment methods? (If you answered no to this question please skip to question 20)

- ☐ yes
- ☐ no

18. What components did you draw from in creating this assessment? (For example, a particular theory, research data, etc.)

19. How is this assessment tool used?

Length of survey

Individual vs. Group environment

Is there verbal discussion with the patient?

Level of participation of the therapist

20. Please share any other information that is important in explaining your overall assessment process.

APPENDIX E: Anonymity of respondents

Help Center - Answers

Page 1 of 3



Help Center

[Answers & FAQs](#)
[Tutorials](#)
[My Questions](#)
[Contact Support](#)

Search Results » "anonymity"

How do I collect anonymous survey responses for confidentiality?

There are a couple of ways to collect anonymous responses in the Analyze section:

1. Through the use of an anonymous collector or the **Web Link** collector.
2. Or by configuring the link sent out on your behalf by SurveyMonkey to not save the email addresses in the Analyze section.

Important! In the Edit Recipients section of that Email Invitation collector, you can still click on the actual email address contained in the list for the tracking purposes. The following will happen and you cannot disable this:

- A prompt will open allowing you to Analyze or Remove that response. If you click the Analyze button, it will open the response to the Analyze section.
- The "email" field will be blank on the response; however, the response itself will open.

1. Web Link or Anonymous Collector:

One way of collecting anonymous survey responses is to create an anonymous collector. This is considered the Web Link collector.

This will be the option you want to use to have the survey completely anonymous!

- ✓ Any response that comes back associated with this link will be anonymous.
- ✓ To be completely anonymous, you can also configure the [Collector Settings](#) to not save the IP addresses in the Analyze section.

Search Answers

anonymity

Documentation

New customer? Get up to speed quickly with our guide.

[SurveyMonkey User Manual \(PDF\)](#)

Need help designing more effective surveys?

[Best Practices for Survey Design \(PDF\)](#)

Returning customer? Learn about our recent upgrades.

[Conversion Guide \(PDF\)](#)

Most Popular Questions

How do I send the survey link through my own email client - A Web Link collector?

What is a Collector and how does it work?




Are your surveys accessible using nonvisual technologies?

How do I check or remove the bounced emails that did not receive the survey?

How do I send the survey through

Step 1:

Click on the Collect icon next to the survey title. This opens the page that allows you to create a collector.

Current Folder:	Everyday Surveys	Manage Folders	Title Search		
Survey Title [sort]	Created [sort]	Modified [sort]	Design	Collect	Analyze [sort]
Example Comment Survey	Thu, 10/12/06 3:26 AM	1 hour ago			 7

★ The collector you create will determine what kind of link is created and how it is to be administered.

SurveyMonkey's Email Invitation Collector?

Can't Find an Answer?

We're always here to help. Just contact our support staff, and we'll get your question answered quickly.

Step 2:

In the collection set up, you will choose the **create a link to send to an email message or to place on a webpage** option.

- Name the Collector.
- Move on to the settings and restrictions section using the Next Step >> button.

[If a previous collector has been created, you will click the Add New Collector button instead.]

How Would You Like to Collect Responses?

1. ☒ **Create a link to send in your own email message or to place on a webpage**
The simplest and fastest way to collect responses. We generate a link for your survey that you can just copy and paste.

☐ **Upload your own emails and have us send a survey invitation**
You can upload your emails, and we will send a survey invitation on your behalf. You can customize the message that is sent, and track who responds in your list.

☐ **Create a popup invitation for your webpage**
We give you the code to generate a popup invitation on your own webpage.

Enter a Name for this Link:

2. Name: (max 30 characters)

3.

Step 3:

You will then copy the link generated under the **Get Survey Link** button and paste it into the body of the message to be sent through your own email client.



2. Email Invitation Collector - Message Delivered by SurveyMonkey:

If you create an Email Invitation collector and use the Edit Recipients section to create an email list, then SurveyMonkey sends the survey out on your behalf.

- If you wish to keep the email/name anonymous, you can choose to not have the email or IP addresses saved on the actual responses.
 - The actual email address status will still be tracked of who has and who has not responded.
 - The email will not be visible under the Analyze section with the response, but you can still click the email in the Edit Recipients list to open up an option to Analyze it or Remove it.
- This option is located under the collector's Change Settings button when you set up the email collector.

Related Answers:

How do I not save the email addresses on the survey responses?
 I don't want to collect the IP addresses on the responses. How do I do that?
 What are the Collector Settings?

[Back](#)

APPENDIX F: Item 6 “Other” Responses
“What clinical population do you MAINLY work with”

- developmental delays
- Parkinson's
- acute psychiatric
- I work in a hospital setting with multiple populations, physically ill-
psychotic-personality disorders- dual- grief/loss
- Triple Diagnosis: HIV+ with sub. abuse and Axis I, or Axis II
- my private practice has all of these issues
- Orthopedic issues incl. somatic issues
- Inpatient Psychiatry
- special ed & families
- college students, MA students
- geriatric
- All conditions, have worked throughout my over 50 years of working as a
DMT in every kind of institution, and treated in private practice all emotional
and physical conditions
- many of the above

APPENDIX G: Item 8 “Other” Responses
“List the most common diagnoses of this population”

- Down syndrome
- Strokes, physical disabilities
- Orthopedic issues incl. somatic issues.
- Anxiety Disorders
- morbid obesity
- Community Hosp mix dx unit, many dual & 3 dx per pt.
- mood disorders, reaction attachment disorders, personality disorders, etc, etc

APPENDIX H: Item 9 “Please Explain” Responses
“Do you assess your patients?”

- intake assessments are not part of my role
- Not required within job description
- Non-profit arts agency requires no CLINICAL assessment, so assessment is utilized for personal treatment goals
- groups are open to all clients
- not on paper, but all the time as a clinician
- It is a very short term facility ... my assessment is done on the spot to help me with my work with that patient in the moment the only "assessment" I do is to read their psychiatric assessment and identify the few areas that our department of activity/expressive therapy might help with.
- there are clinic counselors doing the assessment

APPENDIX I: Item 10 “Other” Responses
“Aspects that are most important to consider when assessing patients.”

- therapeutic process
- Immediate Clinical Intervention

APPENDIX J: Item 11 “Please Elaborate” Responses
“At what point in the therapy process do you assess”

- I observe the client's movement qualities during the course of therapy to be sure we are making progress toward the goals established in the initial movement assessment, and to see if new goals should be added.
- I need to determine which children I recommend to receive DMT and then I do a more full assessment to get a better picture of the child and set goals
- P.D. clients have ON & OFF times, so each assessment done needs to reflect this event.
- I do an evaluation after receiving a referral form from the IEP team. I assess and give my report at an IEP meeting. I document progress on the online IEP every 9 weeks.
- I chart on every patient after every group. This progress note is read by the entire treatment team.
- An initial assessment is completed during or prior to the first session and then just prior to discharge or transfer to another level of care or facility documenting outcome measures of treatment provided.
- Classroom observations for a few sessions, and then there are six weeks of evaluation during treatments.
- I observe the client in the initial session, which tells me how the client relates in a new setting- part of his discharge goals- to move on from the program. It is then on-going, to facilitate the client's progress as he finds his internal resources and independence from the program.

- The required paperwork suggests written assessments be completed seven days then fourteen after admission. However, there are daily and weekly progress note observational assessments.
- The setting (Acute, Short-term Psychiatry) requires immediate assessment, which is ongoing (throughout Pt.'s stay/participation in group tx.), to inform clinical intervention within sessions which makes up the majority of therapeutic interactions b/w Pt. & clinician.
- I keep notes on each session. I assess patients' progress in each session and compare these to the overall goals set in the first two sessions.
- I start off with a standardized overall functioning assessment, develop my treatment goals and from there utilize observation and the therapeutic process to continually assess the patient's progress.
- dementia is a degenerating illness...symptoms and status decline continually therefore repeated periodic assessment is highly necessary
- Due to less time with patient, I need the assessment for setting goals in spec. ed. With families, it is imperative that I have a real relationship assessment in order to be effective.
- Because I lead open groups and see individuals occasionally, I do some form of assessment with each form of patient contact. Naturally, the more contact I have, the more sophisticated my assessment becomes.
- The first group the pt. attends allows me to get a baseline understanding of psyche and then it becomes an on-going process since my work is process-oriented.

- I use an evaluation to form treatment plan early on and assess as I go along.
- I use my observations and learning about the client over time to continually assess what is happening for them and how to intervene rather than relying on a particular assessment tool.
- I assess daily, as my members are humans, and their lives are constantly in a state of change (as we all are)
- Patients are clinically assessed during the first 8 sessions and then at 12 week intervals.
- We explore the reasons behind beginning the therapeutic relationship and then assess as the therapy progresses and mood and cognition shifts.
- patients are assessed in an ongoing way.
- The initial assessment usually happens within the first few sessions, with consistent and continuous observation. This initial assessment aids in developing long term and short goals for the client which coincides with the client's individual treatment plan (ITP) which is developed and administered by the clinical team and the facility staff. As a dance/movement therapist I assess my client in every session in order to meet them where they are in the present moment, and in order to meet their current needs.
- Assessment of repeated or new themes is continual
- first is too early depending on the therapeutic needs further assessments follow irregularly

- Initially, we complete paperwork assessments within the first 2 days of a patient's admission. After that, we assess patients and complete progress notes throughout their hospital stay.
- I assess all the time, during sessions, between sessions, every observation, every interaction is an assessment as well as an intervention
- I read their charts before actually meeting them and then I observe them briefly on the unit and during the session ... I often might only work with a patient once or twice.
- I am an contract therapist. I have a co-leader who is a faculty in this setting. We talked through each client regarding their progress after each group using LMA.
- Writing movement observations after every session gives direction to a previous assessment and how it may or may not be transforming.

APPENDIX K: Item 14 Responses
“What informal methods do you use?”

- observation and reflection on that
- Session notes and discussions with staff.
- I also use basic dance fundamentals-musicality, rhythm, phrasing, etc.
- N/A
- I check in with energy in the body, and use my intuition (or, perhaps my personal interpretation of Kestenberg 'tension-flow attributes" to see where the client is at emotionally and socially that day. I can usually make good interventions with this alone.
- MSE, history taking, communication and cognition, comprehensive development assessment (when applied to children), treatment planning
- My 40 years of experience working with people. Ph.D in Dance/Education and healing. The Thinking Body-The Feeling Mind tmsm
- I would consider my approach semi-formal in that I use the Laban & KMP fundamentals each and every day, however, none of this is written down, and I am not always able to verbalize the clinical rationale for my interventions.
- Motivational Assessment Scale
- None
- Use of self
- I use my knowledge of lma and kmp to inform my nonverbal interventions at all times
- I use mostly LMA.

- combining ideas from KMP and efforts, i look at patients use of posture, effort, strength, and movement quality.
- Understanding psycho-social through psycho-dynamic lens of attachment patterns and speculating on mother-infant/child relationship.
- breathing, grounding,
- My personal observations of the clients' movement style, patterns, tendencies, and movement qualities not present.
- my daily conversations with members and what I observe in their interactions with others throughout the day in program.
- Tension or flaccidity, coordination, energy to complete the task, extramovements
- individual, dyadic and group behavior observations
- psychoanalytic: object relations, self psychology, attachment patterns
- As I conduct my session I will observe thru my effort/shape lenses and will be noticing their interpersonal style.
- Creative process capacity. Can a patient self generate a response to a verbal indication? Does the patient need the other (myself or other patients in the group) as creative resource?

APPENDIX L: Item 15 “Example” Responses
“Aspects of movement MAINLY focused on when assessing patients”

Body:

- for self concept
- areas held, is there integration of movements through body?
- right/left integration, upper/lower integration
- awareness and engagement
- Body attitude and viewed muscular armoring are significant in assessing "where the patient is at", at the beginning of treatment and gives some historical foundation to the development of the personality.
- Posturing
- Color, fluidity, energy (shut down or open) eye-contact
- composition, posture
- yes
- body posture, gesture, kinesthetic energy & awareness
- Physical Limitations, range of motion
- Assess overall body organization and the usage of trunk.
- detachment of the body, enmeshment with the body
- body part awareness & range of motion are constantly observed for changes good and bad
- range of motion, posture
- A basic gross motor eval
- how their posturing (KMP-effort) looks in environment around them

- I look at their breath and movement.
- alignment, movement patterns present and not present
- if they are concave posture in relation to external world
- mindful awareness of sensation and thought
- kinesthetic awareness in relation to body awareness, coordination, control and spatial awareness
- Coordination, locomotion
- posture, direction, tone
- use of body and boundary awareness
- see where is the developmental stage
- posture, movement in space, spatial relationships with others

Effort Qualities:

- to assess inner attitudes/motivation
- How direct/indirect relate to male/female
- bound/free, direct/indirect, strong/light, quick/sustained
- increase coping skills and healthy expressing
- this helps to assess what to do with child
- usually detects chemical abuse
- preferences, difficulties
- yes
- Heavily relied upon to shape clinical interventions along the four qualities' continuum

- restricting movements, flowing movements, random, out of control movements
- unobserved efforts are explored in sessions to increase mvmt repertoire
- strength, quickness
- needed for qualitative movement
- I take note of preferred efforts
- what is present or not
- Assessed after each session for developmental change
- affinities of effort and incongruencies in effort and issue
- Sustained/quick and so on
- Yes
- intensity or lack of effort
- what efforts are utilized/underutilized
- to aware their inner drives
- Does the movement indicate intention

Pre-effort Qualities:

- Psychosis
- see #14
- Not yet integrated...
- same as efforts
- yes
- if they're noticeable, this is an important indicator
- utilized/underutilized

- How is the patient trying to become intentional?

Shape:

- grow/shrinking, widen/narrow, rise/sink, advance/retreat
- social skills
- yes
- Working toward integration
- bringing people and objects into one's space, pushing people and objects out of one's space
- posture, focus, response to props
- I take note of use of shape
- gathering/spreading
- yes
- body shape
- Can the body shape modulate in a session?

Space:

- the child's preferred planes are a strong indicator of their developmental level, needs, and what they will enjoy in movement
- preferred kineshpere for interaction
- spatial awareness
- how they use space
- social availability with others
- awareness, perception
- yes

- Working toward integration
- Spatial Awareness,
- Look at size of kinesphere.
- utilization of space, over taking space, disappearing within the space,
awareness of one's space
- focus, extension (reach)
- I see how bodies interact with the space around them.
- I will note how they utilized their personal space
- how they behave/interact in their space
- observation of use of space and trust in mobility
- in order to increase awareness and appropriate use of spatial boundaries and
personal space
- near reach and far reach space
- awareness/use of space
- How is the patient relating to internal/external space?

Interaction:

- How it can be done in a wheel chair, walker, or not.
- eye contact, touch, approach
- social skills
- key to development/ separation/individuation
- see above
- isolative, outgoing
- yes

- Group dynamics, attunement, attachment behaviors
- initiating, responding, detachment, unawareness, engulfing, enmeshment
- I look for developmental relational satisfaction, molding, mirroring and witnessing needs
- visual tracking of therapist, peers, verbalizations
- Needed for use with families
- how much they do
- 100% of my work is executed and assessed through the interaction.
- body attitude while interacting
- Interaction with the therapist
- observation of clinical relationship
- direct and indirect
- yes
- gaze, postural direction, PGM's, initiating, etc.
- how the individual relates to their surroundings
- social interaction style
- isolation or interaction in for any given intervention

Diagnostic Indicators:

- completion of phrases
- Since part of my clinical work is forensic, diagnostic indicators play a significant role toward assessing competency and responsibility (as requested by the courts).
- not sure what that means in DMT

- mood disorder, thought disorder, personality disorder
- DSM IV indicators
- Previously I used this for adult patients, now the children assessment is folded into MPI
- tics, tremors
- pressured movement = hypomanic, passive weight = vegetative depression, etc.
- Laban

Developmental Stages:

- helps understand "uneven" or "atypical" psychosocial development and devise effective treatment plan
- working with young children, this helps me see where they are developmentally and what is the appropriate role for me to take in working with them
- This synchronistically identifies both developmental stage of dysfunction and also strengths of the patient. This also identifies for me how to best communicate with the patient based upon their preferences.
- transitions, fixations
- Developmental Tension-flow Rhythms used in warm-up as group assessment tool
- age appropriate behaviors
- I look a lot at developmental movement mastery from KMP and Bonnie Cohen

- always with children
- yes
- What kind of rhythms are available to use

Body Image:

- How does the body image change from before PD to now
- body part awareness
- self-esteem, motivation to change
- yes
- less verbalized in my setting
- positive and negative behaviors and attitudes projected regarding body image
- in terms of proprioception (accuracy vs. inaccuracy)
- in group, how they are able to define, and share about their own body image
- What client says about this compared to what their body language tells me
- confidence building and resourcing of internal strength

Group Behavior/Participation:

- How does the couple relate with or without words,
- Socialization
- yes! How much, how little,...HOW
- positive risk taking, fear-avoidance
- yes
- Yes, similar to Interactions and Dx. Indicators above
- Social interaction, awareness of environment,

- interpersonal interactions and establishment and respect of personal boundaries
- engagement, visual focus, physical contact, initiation
- how they are in a group with me as facilitator and with peers
- I use my group process skills to assess patients.
- I definitely look at how group dynamics emerge with clients
- if it is present and what it is
- focuses on interpersonal interaction between client and peers, and client and staff
- Interactive relationship, lead/follow and so on
- Yes
- Yalom as in subgrouping, spokesperson, peer interaction, etc.

Other:

- and how does it effect group participation.
- triggers to various movements
- I really use all of the above
- rhythm, upper/lower body
- all of the above!
- unfortunately, our formal assessment is not specific to DMT
- overall this question is really unclear

APPENDIX M: Item 16 “Other” Responses
“Employment of published DMT-related assessment tools in their entirety”

- Explanation of KMP: I do not use the entire profile for the obvious reasons of time expenditure required to complete the full profile.
- I developed my own based on LMA, KMP
- Espenak Assessment (from her book)

APPENDIX N: Item 18 Responses

“What components are used in creating individually-developed tool?”

- Effort shape (although I am not a CMA), Kestenberg, Marion North, my thesis research
- KMP, assessment tool created by a DMT previously at my site, sensory integration
- The training given by the National Parkinson's Foundation on the complete development of PD and how it relates to the client.
- I video every assessment session and then once a year. I blend my training on the BRIAAC (Behavioral Rating Instrument for Atypical and Autistic Children) with effort/shape observations.
- development theory etc.
- systems theory, family structure, existential and spiritual well-being
- All of the above.
- I drew on LMA and Dianne Dulicai's assessment of ego strength and coping skills.
- Developmental relational movements from attachment theory and object relations
- LMA, KMP, Chakra system
- approach is based in Kestenberg developmental stages
- sensorimotor psychotherapy existential philosophy
- LMA and KMP
- Laban, expressive dance, kinesiology, Lowen,

- Our department, made of various therapists, developed an assessment that includes BASIC info about the patient: why they were admitted, what coping skills they need, affect/mood, etc.
- integration of neurobiology (Schoore); attachment (Siegel, Ainsworth, Bowlby, Winnicott); psychoanalytic dx (McWilliams); LMA and group dynamics (Yalom)
- The assessment I use was created by a DMT employed prior to me at the agency I work at.

APPENDIX O: Item 19 Responses
“How the individually-developed assessment tool is used”

Length of Survey:

- 2 pages, usually a 20 minute observation period
- half hour
- 30-45 minute eval session, then I watch video and write up my recommendations as to whether dance therapy is necessary in order for the child to benefit from his/her educational setting.
- 2 pages, it takes about 15-25 minutes
- one page
- 2 page
- on-going
- 3 pages
- child is given tasks
- continued processing of mindfulness / consciousness
- 3 pages
- not sure what you mean by this question
- 3 pages
- one page

Individual vs. Group Environment

- usually conduct observation of individual in group setting
- playground/movement room free play time with group
- ind

- individual
- individual
- individual
- individual
- Both
- individual only
- individual
- Individual and also dyad movement
- Individual
- Both
- can be used for both group and individual
- group

Verbal Discussion with Patient:

- kept to a minimum during observation
- no
- yes
- yes-if patient is able
- yes
- yes
- yes
- yes
- sometimes
- Yes. But not about doing an assessment.

- Sometimes
- Yes
- No
- Yes
- Yes
- Sometimes
- Yes
- No

Level of Participation of the Therapist:

- Minimal
- observer only
- interactive and soliciting movement behavior
- high
- fully engaged
- high level
- active
- high due to relational quality of assessment
- Active or simply observation on the unit
- engaged fully in each session
- mutual guiding
- unsure
- empathetic and also counter-force movement, part of the time
- we interview them

- lots of movement interaction
- can vary
- ?

APPENDIX P: Item 20 Responses
“Other information important in assessment process”

- Basically, the movement assessment is a tool to determine the client's movement strengths and weaknesses. Based on it, therapy can effectively strengthen and expand the client's movement repertoire, ultimately affording her/him a greater range of psychological resources.
- Assessment is done informally therapist to client. It can be done in person or on the phone. Keeping the sessions normal/natural are very important to the clients and care partners.
- The assessment process may vary in what is requested both by the facility and the court system, i.e. an outright voluntary assessment would differ from what is requested in a forensic assessment, which requires more detail and serves as but one aspect of the clinical teams staffing of a patient sent to the hospital for evaluation.
- I'm a bit embarrassed that I am not familiar with SKIP, FAMP, NVAFS, and Action Profile. Would love to know about these- maybe you can write a 'survey of assessment tools" for the newsletter?
- This is a critical area for growth & development in our field! Good work; I look forward to your results!
- I was perplexed by your separating of the categories of effort/shape and Laban Movement Analysis.
- I work with several creative artists. Few of us are trained therapists. We are not required to use assessments and to encourage my use would further

distinguish the differences between our credentials. This would diminish the team cohesion, at least for now.

- I use videotape for the first assessment.
- I trust my own internal reactions. If my gut tells me something is "up", I pay close attention.
- final assessment is presented to treatment and team and treatment team input is noted
- Intra-body conflict in movement, force and counterforce
- I give input to treatment team on movement behavior and interaction patterns, especially keyed towards assessing medication effects and improvement or decline in patients' functioning
- Sharing and listening to other professionals who are working with the patient. Self -observation of countertansference phenomena is essential as well as supervision.

APPENDIX Q: Accredited DMT Programs—Assessment Courses

Naropa University:

- **PSYS 607—Appraisal:** Student clinicians are provided a working knowledge of the skills and tools used in the clinical process of assessing, diagnosing and treating psychiatric syndromes and populations. The course content explores the basic aspects of psychometric testing including validity, reliability and professional and ethical considerations associated with assessment and testing. In addition, students are introduced to the major diagnostic categories within the DSM-IV-TR as a tool for understanding states of individual psychopathology.
- **PSYS 621—Body Observation and Assessment: Body Psychotherapy:** In this course students look at how the mind is expressed through the body. The focus is placed on gathering the basic terms and concepts necessary to cultivate the skill of seeing the body descriptively both in stillness as well as in motion. A range of observation and assessment models specific to dance/movement therapy and body psychotherapy is introduced: including morphological, developmental, energetic, segmented, process-oriented and archetypal frameworks. The overarching context for encapsulating these concepts is through the lens of Laban Movement Analysis (LMA).
- **PSYS 637—Body/Movement Observation and Assessment II:** Students learn to appraise how ego structures such as self-image, identity, object relations and superego manifest in the body as patterns of alignment, proportion and strategies for balance. Methods are explored for gathering information to clarify the relationship between observed physical patterns and clients' inner physical and

psychological experience, as the basis for developing a treatment plan. Concepts from the movement education systems are applied to treatment strategies.

<http://www.naropa.edu/academics/graduate/psychology/somatic/courses.cfm>

Columbia College:

- **Clinical Assessment and Treatment Planning:** This course helps you build on earlier theory, drawing on movement observation, assessment and psychopathology within artistic and psychological frameworks. Emphasis will be placed on treatment planning, including one to one and group assessment, intervention, and the application of psychological paradigms in accordance with the Theories & Principles of Counseling course.
- **Observation and Assessment of Movement I:** Students will learn and develop skills of observing, documenting, describing, and assessing human movement behavior. Students will learn foundational theory, principles, vocabulary, and philosophy of Laban Movement Analysis through kinesthetic, written, and verbal experience.
- **Observation and Assessment of Movement II:** Students will develop skills for observing and assessing human movement within a psychotherapeutic context, using Laban Movement Analysis as a basis for clinical applications in Dance/Movement Therapy. Students will examine foundational theory, principles, and applications of The Kestenberg Movement Profile.

http://www.colum.edu/Academics/Graduate_Study/Dance_Movement_Therapy_and_Counseling/Course_Descriptions.php

Drexel University:

- **ARTS 554—Movement Observation I:** This course introduces students to movement observation and analysis within the framework of Laban Movement Analysis. In experiential and didactic frameworks, students will examine personal, relational, cultural, and societal dynamics as manifested in movement behavior. Therapeutic implications for both individuals and groups will be discussed.
- **ARTS 556—Movement Observation II:** This course further develops student skills in movement observation and analysis within the framework of Laban Movement Analysis. In experiential and didactic formats, students will examine personal, relational, cultural, and societal dynamics as manifested in movement behavior. Therapeutic implications for both individuals and adults will be discussed.
- **ARTS 603—Clinical Appraisal and Assessment I:** An introduction to major established instruments and scales in intellectual, behavioral, social, emotional, developmental, and neurological testing. Students learn theories of clinical appraisal and testing, interviewing for mental health functioning, and skills of professional case presentation, with an emphasis on case conceptualization and holistic assessment.

- **ARTS 607—Clinical Appraisal and Assessment II:** Continuation of ARTS 603: Clinical Appraisal and Assessment I
(<https://duapp1.drexel.edu/webcourses/CourseListing.asp?SubjCode=ARTS&Level=GR&Univ=DREX>)

Antioch University New England:

- **Fundamentals of Therapeutic Interaction**
- **Expressive Arts Therapy**
- **Dance/Movement Therapy with Children**
- **Dance/Movement Therapy with Adults**
- **Counseling Theories: Models and Approaches**
- **Group Dance/Movement Therapy**
- **Social & Cultural Diversity in Dance/Movement Therapy**
(<http://www.antiochne.edu/ap/dmt/degereqs.cfm#MAmtcp>)

Lesley University:

- **GPSYC 6205: Assessment for Counseling and Psychology: Adults**
- **GPSYC 6255: Assessment for Counseling and Psychology: Adolescent and Child**
- **GEXTH 6258: Movement Observation I**
- **GEXTH 7013: Movement Observation II**
(http://www.lesley.edu/gsass/exp_ma_dance_mental_health_spec.html)

Pratt Institute:

- **DT-673: Movement Behavior I**
- **DT-674: Movement Behavior II**
- **SS-630: Clinical Diagnosis & Treatment Issues**

(<http://www.pratt.edu/arttherapy>)

